East Kent Hospitals University NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS MEETING
THURSDAY 30 MARCH 2017, 09.30

Please find attached the agenda for the next Council of Governors Public Meeting to take place at **Julie Rose Stadium, Ashford TN24 9QX**

AGENDA

*Refreshments available from 9.00*am

CLOSED SESSION To be held from 09.30 – 10.00				
1.	Minutes of the closed meeting held on 24 November 2016	Appended		Nikki Cole Trust Chair
2.	Holding NEDs to account for the performance of the Board			Michèle Low Lead Governor
3.	Confidential update on developments:			Nikki Cole Trust Chair
PUBLIC SESSION Please note that this session starts at 10:00				
1.	Chair's Introductions Welcome to new Governors			Nikki Cole Trust Chair
2.	Apologies for Absence and Declarations of Interest			Nikki Cole Trust Chair
3.	Minutes from the last Public Meeting held on 24 November 2016 and matters arising	**Appended**		Nikki Cole Trust Chair
STRATEGIC 10.05 – 10.25				
4.	Special Measures	**Discussion**		Nikki Cole Trust Chair Matthew Kershaw Chief Executive
5.	Quarterly discussion with NHS I	**To note**	**CoG 01/17**	Michèle Low Lead Governor
GOVERNANCE 10.25 – 10.35				
6.	Trust Statutory Declaration to NHS I – process	**To note**	**CoG 02/17**	Alison Fox Trust Secretary
7.	Governor Travel and Expenses Policy	**To agree**	**CoG 03/17**	Alison Fox Trust Secretary
8.	Register of interests	**To note**	**CoG 04/17**	Alison Fox Trust Secretary

We care

MEMBERSHIP 10.35 – 11.05				
9.	Communications & Membership Committee report. To include feedback on elections.	**Discussion**	**CoG 05/16**	Matt Williams Chair CMC Elected Governor with:
REPORTS 11.05 – 12.50				
10.	Report from Trust Chair • CIPs update & Agency Spend	**Discussion**	**CoG 06a/17 06b/17**	Nikki Cole Trust Chair
11.	Report from Chief Executive	**Verbal report**		Matthew Kershaw Chief Executive
BREAK 15"				
12.	Council of Governor Committees			
	• Finance and Performance Committee: TBC	**Discussion**	**CoG 07/17**	Michèle Low
	• Nominations & Remuneration Committee: Chair & NED appraisal NED recruitment update	**Discussion**	**CoG 08/17**	Philip Wells
	• Quality Committee: Quality accounts Blue Badge parking	**Discussion**	**CoG 09/17**	Sarah Andrews
	• Workforce Committee People Strategy	**Discussion**	**CoG 10/17**	Sarah Andrews
	• Audit and Governance Committee Procurement process for Well Led Review	**Discussion**	**CoG 11/17**	Chris Warricker
BUSINESS: 12.50 – 13.00				
13.	**QUESTIONS FROM MEMBERS OF THE PUBLIC**			
14.	**ANY OTHER URGENT OR IMPORTANT ITEMS**			Please notify Committee Secretary of matters to be raised – deadline 48 hours before meeting
15.	**DATES OF FUTURE MEETINGS**	Below		

Dates of future meetings: TBC

PRIVATE AND CONFIDENTIAL

UNCONFIRMED MINUTES OF THE COUNCIL OF GOVERNORS PUBLIC MEETING 24 NOVEMBER 2016, 10.15

The Cathedral Room, Best Western Abbots Barton Hotel, Canterbury, CT1 3DU

PRESENT:

Nikki Cole	Trust Chair (Chairman)	NC
Alan Holmes	Elected Governor – Canterbury	AH
Chris Warricker	Elected Governor – Canterbury	CWa
David Bogard	Elected Governor – Staff	DB
Eunice Lyons Backhouse	Elected Governor – Rest of England & Wales	ELB
Jane Burnett	Elected Governor – Ashford	JB
John Rampton	Elected Governor – Staff	JR
John Sewell	Elected Governor – Shepway	JS
Junetta Whorwell	Elected Governor – Ashford	JW
Mandy Carliell	Elected Governor – Staff	MC
Margo Laing	Elected Governor – Dover	MLa
Matt Williams	Elected Governor – Swale	MWi
Michèle Low	Elected Governor – Shepway	MLo
Paul Bartlett	Elected Governor – Ashford	PBa
Paul Durkin	Elected Governor – Swale	PDu
Philip Bull	Elected Governor - Shepway	PBu
Philip Wells	Elected Governor – Canterbury	PW
Reynagh Westcar-Jarrett	Elected Governor – Thanet	RJ
Sarah Andrews	Elected Governor – Dover	SA
Debra Teasdale	Partnership Governor – Canterbury University	DT
Chris Wells	Partnership Governor – Council	CWe
Michael Lyons	Partnership Governor – Volunteers	ML

IN ATTENDANCE:

Barry Wilding	NED	BW
Sunny Adeusi	NED	SAde
Matthew Kershaw	Chief Executive	MK
Paul Stevens	Medical Director	PS
Natalie Yost	Director of HR and Engagement	NY
Alison Fox	Trust Secretary	AF
Amanda Bedford	Committee Secretary (minutes)	AB

MIN.NO		ACTION
56/16	**CHAIR'S INTRODUCTION** NC welcomed participants to the meeting. NC noted that four questions had been submitted (two from CW, two from JS). She undertook to address the questions from CW during the financial section of the meeting and it was agreed she would provide written responses to the questions submitted by JS.	

	ACTION: Chair to provide written responses to the questions submitted by [John].	NC
57/16	**APOLOGIES FOR ABSENCE AND DECLARATION OF INTEREST** Apologies for absence were received from: Carole George — Elected Governor – Dover Marcela Warburton — Elected Governor – Thanet Robert Goddard — Elected Governor – Staff Roy Dexter — Elected Governor – Thanet Colin Tomson — NED Gill Gibb — NED Satish Mathur — NED	
58/16	**MINUTES OF PREVIOUS MEETING AND MATTERS ARISING** The minutes of the meeting held on 5 September 2016 were agreed as an accurate record, with the following amendment: Michèle Low, Elected Governor for Shepway, not Dover.	
59/16	**MATTERS ARISING** Updates were provided as follows: • Visibility Programme: NY reported that the Executive Team and Board members had been engaged in a programme of activity to raise the visibility of Board. This had involved ward walk-throughs, visits to services and work shadowing. Various communication channels had been used to publicise when members of the Board were visiting sites and to update on other ad hoc activities. Feedback from staff had indicated the Board was more visible. Feedback provided during the CQC forums had been very positive and had recognised the extra visibility of the Board. This was a key aspect of the communications and engagement strategy. • Terms of Reference: Only the Workforce Committee Terms of Reference were outstanding. • Matron Review: to be conducted in early 2017 (date TBC) The following points were raised: • CIPs: CW requested a summary of the plan and progress to date to indicate how the Trust was performing against the objectives. MK undertook to provide a two-page summary, but cautioned that this would not provide the finer details and it was likely that more detailed questions would arise (perhaps moving beyond the remit of the Council). SA assured the Council that NEDs were holding the Board to account for performance. CW noted that there was a history of this project failing and he did not feel that verbal assurance from NEDs sufficient to demonstrate progress against the	

	objectives. ACTION: provide a summary on the current state of the Trust's CIPs' programme. • MLo noted that the Council Finance Performance Committee had discussed what information should come to Governors. She advised that the Committee had generally felt the amount of information coming to Council was appropriate. She noted that recommendations had been made during that meeting and these were outlined in the minutes that would be presented later in this meeting. The discussion was put on hold until the presentation of those minutes. • RE noted the importance of balancing the CIPs programme with quality, safety and other risk dimensions of delivering healthcare. He advised that he was comfortable making explanations about Board decisions that may lead to one programme missing its CIP target in the interests of delivering a safe service. He would not be comfortable delivering a CIP programme that did not take sufficient account of risk and quality. CW asked if risk and quality had been considered when the target was set. It was confirmed that these factors had been considered, but it was acknowledged that the Trust was prone to change. • It was noted that demographic data presented at the last meeting had not been reliable and a request was made for the correct data to be presented to the next Council of Governors meeting.	MK
60/16	**JOINT GOVENOR/NED MEETING FEBRUARY 2017 – PLANNING** NC reported that the Board would be holding a strategy session in February and suggested that this could include a Joint Governor/NED session. She also suggested holding a facilitated session on how the Council and the Board of Directors could work more effectively together. She invited feedback/further suggestions from the Council: • MLo sought to clarify the February meeting would be a strategic planning session. It was confirmed that the objective was to bring Council of Governors and Board of Directors closer together and to enable the Council of Governors to have input into the strategic direction of the Trust. • It was suggested that case studies could be used in the session rather than actual situations to ensure some emotional distance. • It was suggested a discussion could be held about the induction process for Governors during the session.	
61/16	**ANNUAL REVIEW OF REGISTER OF INTERESTS AND FIT AND PROPER PERSONS DECLARATIONS**	

	NC reported that members of the Council of Governors must make annual self-declarations of their interests and their status as a fit and proper person. AB advised that there were declarations outstanding and she would continue to chase these. She undertook to advise the Governors by email once the declarations were complete. ACTION: Members with outstanding declarations to complete these as soon as possible. AB to circulate advice when this is complete. AB to circulate the register of interests once it is complete.	GOVS/AB
62/16	**ELECTIONS 2017 – UPDATE** NC invited questions from the Council: • PBa advised that he had been precluded from nominating himself for the Council of Governors of the Ambulance Trust because he was a member of the East Kent Hospital University Trust Council of Governors. AF confirmed the national guidance that individuals could only sit on the Council of Governors of one NHS Trust given the potential for conflicts of interest. • There was a question raised about whether there would be a similar issue with a Member of the Council also being a member of KCC. AF undertook investigate this. • It was suggested that the statutory requirements had been set some time ago and were not appropriate in the changing environment. NC undertook to investigate the enforcement of preclusions and to advise the Council of Governors of the findings. ACTION: Identify Council election preclusions and advise the Council of Governors of the findings.	NC
63/16	**MEMBERSHIP ENGAGEMENT AND COMMUNICATION COMMITTEE REPORT** MWi highlighted the following: • The first newsletter written specifically for members would be presented to the MECC on the 1 December and released once the content was approved. • The Charitable Funds Committee had been invited to propose ideas on how Governors could assist the Charity and its work. • Work continued on the Governor area of the website. • Proposals had been made about improvements that could be made to the Annual Members Meeting (AMM). This included ensuring that the meeting did not become a forum where personal grievances could be aired/discussed. PALs could be onsite to discuss issues at future meetings. • Suggestions had been provided for the Governors' section of	

	the Your Hospital magazine. MWi invited the Governors to make a contribution to the magazine. • Strategy discussions had included considering ways of improving "Meet the Governor" events. • There had been a discussion about the cultural difference between the public and members with it being recognised that members must feel consulted and involved in the decision making of the Trust. Consideration must be given to the methods of communication (mail-out is not financially viable, electronic preferable). MWi emphasised that the Trust magazines was circulated through community agencies rather than by mail to individuals. NC invited questions or comments: • RJ noted that the venue for the AMM had presented problems for older members (steep auditorium). He also suggested that there would be no questions if personal stories could not be aired at the meeting. • It was noted that there was no information readily available to provide to people interested in becoming members of the Trust. There was a question about why the application form was so extensive, with the inclusion of so many ethnic group and sexuality options available for selection. It was advised that this was a requirement of NHS Improvement and allowed the Trust to ensure they were as representative as possible and could target certain hard to reach groups. • ML sought clarification about the purpose of the word "exclusivity" on the last page (bullet point one) of the report. It was noted that this was a misprint. The following AMM options outlined in the paper were discussed by the Council: (a) The AMM to meet the statutory duties only, keeping investment to a minimum and focusing energy on other public member events. (b) The AMM to meet the statutory duties, arrangement/agendas as this year while addressing points raised about venue access and content. (c) The AMM to meet the statutory duties but build on the existing format and timeliness to create a higher profile, bigger and broader event catering to members, media, hard to reach communities; and used as a key part in the Communications strategy. • It was suggested that the AMM should be held in the evening/night in April. It was noted that it had originally been planned for September, but the CQC visit had clashed. It was noted that the financials had to be signed off (end June/early July) and August was a holiday period. The earliest the meeting could be held would be September.	

	• In general, the Council agreed that this should be considered to be a major event and they were supportive of the (c) option outlined above. • DT noted that the evening option was difficult for families with children. It was suggested that a Saturday could be better option. She also suggested she could provide a potential solution to the venue issue. SA supported this suggestion, as did the majority of the Council. • MLo had been pleased to see the Executive attend the AMM, but noted her disappointment and the lack of attendance from the NEDs. It was acknowledged that GG and RE had been present. • ELB suggested that as well as PAL team members being present, there should also be attendance from [PET]. • PW asked if consideration had been given to opening the meeting to the public. It was noted that it was a statutory requirement that the meeting be held as a Member's Meeting, but the public were invited to attend. AF suggested that the next meeting could be called the AGM/AMM. DECISION: The next AMM to be held on a Saturday in early September. The Council agreed that the AMM should fulfil its statutory duties but build on the existing format to create a higher profile, bigger and broader event catering to members, media, hard to reach communities; and should be used as a key part in the Communications strategy.	
64/16	**REPORTS FROM COMMITTEES** **Chair's report** NC provided the following update to the Chair's Report: • In addition to the Board meetings, a Board to Board had been held with the East Kent CCGs, which had been attended by the lay members of the CCGs. During the meeting there had been discussions about new models of care, the governance of the STP and the two year planning process. • She advised that she had attended the TIPs (teams improving patient safety) Project Reporting (Internal Transition Methodology for Change) and had noted the projects which were making a material difference to the way the Trust was working. • She had spent time shadowing Dr David Hargreaves on the Stroke Unit.	
	1. Chief Executive's Report MK provided the following update: • The draft CQC Report would be received at the end of November; the improvement work continued with the Improvement Plan being updated to reflect the CQC feedback received to date. It would be further updated when the report was received. • The STP document had now been published. Communication	

	and engagement strategies were being further developed. • The financial position remained challenging. The Trust was broadly where they expected to be. NHS Improvement had been informed that the best case scenario would be a £19m deficit, the likely scenario would be £24m deficit and the worst case would be £30m. Achieving the CIP targets would be a key focus, but there would be balance between financial and quality/safety objectives. Vacancy control would be a key aspect of cost savings. • With respect to Operational pressures and performance, MK reported there had been positive progress on the elective pathway and on cancer. Meeting the Emergency Care four hour target was proving challenging given much of the issue related to the wider health community (i.e. delayed transfers of care). Conversations were being held with community partners about moving forward on this issue particularly through the winter months. • MK reported that he was broadening connections with universities, and local schools to encourage consideration of careers in health. • The contracting round was underway and a deadline had been set for 23 December. MK invited questions on the Chief Executive's Report: • A nursing home update was requested. MK advised that there were conversations underway about how the Trust could extend the range of services they provided to connect with the community, but there were no immediate plans to develop, build and run a nursing home. There had been discussion about the creation of a Dementia Village in Dover. Funding had been sought from a European grant-making body and the Trust would continue to investigate other sources of funding. • An update was requested about the William Harvey Trauma Review. MK reported that Trauma Review was the process by which the Trauma Centres were assessed to confirm that they were still delivering care to the standards set. There had been no concerns raised about the quality of care at East Kent and in fact had been positive about the clinical processes being utilised. PS confirmed that QEQM was also part of the Trauma Network and both hospitals had performed very well in recent national audits. • An update was sought on the Junior Doctor Industrial Action. MK advised that the Trust was implementing the contract in line with the national timetable. There were doctors working to the national contract. The Trust was supporting and working with doctors on the ground, some of whom did not agree with implementation. Concerns continued to be raised by the Junior Doctor's Committee at the BMA who did not support the contract being implemented. • Given the recent receipt of the single oversight framework, MK was asked if the 'CQC Report' would contain the new ratings system. MK advised that the single oversight framework was separate to the CQC. He advised that if the Trust remained in	

	special measures, they could not be rated higher than Segment Four. • PBu noted that recent experience showed ambulance protocols to be very cautious. He suggested that the threshold could be adjusted once ambulance staff were confident of patient safety, and this could reduce the number of unnecessary ED admissions. MK advised that there were ongoing discussions with the Ambulance Service about protocols. • PBu also asked what could be done to reduce the pressure in ED (without giving consideration to the current financial situation). MK advised that the infrastructure needed to reflect the way that the Trust would run their services in the future. This would include enabling separate pathways so that senior staff could assess, diagnose, treat and send home patients if appropriate. Recruitment would also be a focus. Consultants and nurse practitioner roles could help develop different ways of working. • RJ noted that the improvement teams had been working hard to move the Trust out of special measures and sought advice about what support was being provided to them. MK acknowledged that ongoing special measures was having a negative effect. He noted his view that making further improvement would be easier on the back of success (i.e. being taking out of special measures). It was his hope that the CQC would feel the same way. If it was determined that the Trust would remain in special measures, a communication plan would need to be formulated that could identify the reasons for the decision to staff and still keep them motivated to continue on the improvement journey. He undertook to ensure that staff were provided with the support to continue improvement regardless of the CQC decision. • JW sought more detail on vacancy control measures being engaged within the Trust. MK advised that vacant posts were assessed through the Quality Impact Assessment Process prior to decisions being made about the required level of recruitment. • JW asked about winter pressures and discharge processes noting her concern in particular for the older population being discharged into the community. MK advised that the Integrated Discharge Team included social services, voluntary sector, hospital staff and mental health professionals. He was assured by the work that went into ensuring strong discharge processes, but acknowledged that there were still areas where work was required (e.g. funding continued non-hospital care).	
	Finance and Performance MLo highlighted the following points: • The Committee was seeking more information and assurance on how NEDs were responding to the costs of delayed discharges. • The gaps in the BAF had been noted and the Committee had	

	sought advice on when and how it would be improved/regularly updated. • It had been felt that Committee was not getting the information it required. It was recommended that the agenda setting meeting should have a discussion about the range of information that was currently received and consider what additional information should be provided. Recommendations would then be made to Council for consideration. • A report had been provided on the value for money for the Turnaround Director. • It had been proposed that the Board's Finance and Performance Committee forward planner be shared with the Council's Finance and Performance Committee. NC invited general questions on the report: • MLa felt the response about the Turnaround Director's value for money was not sufficient. She sought more information on this. SA advised that there were two types of Turnaround Director, one which took an aggressive approach, the other was more collegial. The TD the Trust had engaged was described as being the latter. He had created systems/infrastructure whereby the goalposts could be moved and had passed skill sets to internal PMO resource. MLa indicated that she had expected a more aggressive approach to be taken. • It was suggested that a Council of Governors session could be held on CIPs that provided examples of projects that were put forward. • RJ sought to understand whether Divisional management had the necessary skills, information and experience to meet the requirement of Divisional management and budgeting. It had been suggested that this would be under the remit of the Turnaround Director. RJ observed that the Grant Thornton report appeared to indicate that this had not been achieved. • MK advised that the engagement of a Turnaround Director had been required by Monitor. He acknowledged that the TD who had been engaged had been more collegial than aggressive in the interests of creating infrastructure and making progress on CIPs. He also acknowledged that the TD had not been as much impact on CIPs as might have been expected for a range of reasons. In regards to development, he advised that the organisation was in the process of developing leaders to improve their capabilities. NC outlined the questions submitted in writing by CW: • Q1: How many beds are being occupied for non-clinical reasons such as inadequate home care plans? How much and to whom does the Trust charge for the service. • SAde provided the following response: 300 patients in acute care; 90 of whom were waiting to move into a step down facility in social care. This was at a cost of £120 a day. The Trust could seek to recoup the cost. Reducing DTOC required	

	the engagement of social care and a strong programme that operated beyond the boundaries of the Trust. This was being done, but the pace and the scale could be better. • NC advised that the Trust did not currently charge the community partners for the cost of holding DTOC patients in hospital. CW suggested that there was no incentive for community providers to improve the situation. • PS shared the results from a recent Kent and Medway audit on bed usage in hospitals. The East Kent Trust had a total of 316 people who no longer needed to be there. 31% had dementia. He identified the some of the reasons for patients remaining in hospital and outlined the proportions as follows: o 17% awaiting assessment o 2% continuing healthcare o 5% awaiting social care o 9% awaiting nursing home place o 8% required active therapy o 7% awaiting funding decisions o 6% awaiting intermediate care o 5% awaiting residential care homes o 5% disputes with family about where they should go o 4% required specific community equipment. • Q2: NHS Trusts have a duty to make and recover charges from overseas visitors. Can NEDs please explain how they hold the Board to account for its performance on this issue? • SAde advised that the Trust was increasingly making efforts to identify non-European patients who could be charged. There had been an increase in the income being received over the past two years. • NC advised that the number of people being treated from overseas was very small. She also advised that when GPs referred patients, there was an assumption that that the relevant identity checks had already been made. • MK noted the importance of keeping this issue in perspective noting that there was a very small proportion of funds being expended on overseas visitors. He assured the Council that follow up checks were conducted. He noted however, that emergency situations would always be treated without identity checks. • BW advised that this issue was discussed periodically during the Audit Committee meetings and confirmed that this was a very small proportion of funding being expended. The Committee had considered there to be little chance of recouping funds as visitors had often moved on by the time they had been identified as being chargeable. • JW considered it would be difficult for staff to manage questioning of this type. She suggested that identity questions had the potential to create hostility. She suggested the ethics of the request were also questionable. • MWi noted that the administration cost of pursuing these funds was higher than the amount that would be recouped. • A newspaper had reported that the UK was recharged £500m per year by external governments for reciprocal arrangements,	

	but the UK was only charging other governments £47m per annum. NC sought Council advice on the recommendations made in the Finance and Performance Committee Report as follows: (a) Council should have further assurances from NEDs in relation to the significant cost of delayed discharge and invites Council to propose how this can be done. • It was suggested that the Council FPC could ask the relevant NED to supply the evidence required. • It was suggested that this request was beyond the remit of the Council of Governors given there was a clear understanding that there were patients in a state of DTOC and Council could not effect change in this regard. • ML suggested that a regular progress report be provided to Council FPC or to Council on delayed transfers. This was **agreed** with a show of hands. **DECISION:** A regular report to be provided to Council FPC, via BoD FPC, on the progress of reducing DTOC. (b) The Committee recommends to Council it should seek further information on timescales to improve the BAF system and a process to complete the report properly, and noted that it would expect to see the improvements at the next meeting. **ACTION:** Council to be provided with further information, via IAGC, on timescales to improve the BAF system and a process to complete the report properly. (c) The Committee recommends to Council that the Council of Governors Chairs agenda-setting meeting should consider how the Council can review the information it receives prior to a full debate on the matter in Council. • MLo clarified that the Council FPC had not been certain they were receiving the right reports and sought Council's view on this. She noted that if it was determined that the right information was not being received, then it should be discussed in the Chair's agenda-setting meeting. • It was suggested that Council FPC should conduct the deep dive to identify what they were missing in terms of information. **DECISION:** This recommendation **did not pass** on a show of hands (five voted in favour). MLo sought confirmation that Council was happy with the range of information currently being received. This was confirmed.	

	Nominations and Remuneration PW provided the following update: • He thanked the Committee members for their thoroughness during the NED recruitment process. • Terms of Reference had been reviewed and it had been agreed that one NED should be in attendance for a quorum and every NED should attend a meeting at least once a year. PW invited questions/comments on the report: • It was noted that the minutes identified the Quality Committee rather than the Nominations Committee. The Committee made the following decisions on the recommendations outlined in the meeting papers: **DECISION:** The recommendation to ratify the Terms and Conditions of the Nominations and Remuneration Committee was agreed. **DECISION:** The recommendation to ratify the nomination to appoint Keith Palmer to the NED vacancy via a process of virtual voting was agreed. **DECISION:** The recommendation to agree the Draft Effectiveness Survey and Timeline was agreed.	

	Quality
	
	SA provided the following update:
	
	• Background information had included the relevant section of the Integrated Performance Report, the high level Improvement Plan, minutes of the monthly meetings of the Board of Directors Finance Committee and the relevant sections of the Grant Thornton Review.
	• Issues relating to outpatients had continued to surface during the meeting. Two resolutions had been made:
	  o Fulfilling responsibility in relation to members of the public, reports about outpatients to be collated to Amanda.
	  o To seek assurance from the lead NED about the progress with the Outpatient Strategy.
	• Ward Care Reviews related specifically to the Grant Thornton item (R8). A pilot scheme had been run and Governors would be involved in this at the beginning of 2017.
	• Commentary was to be provided on the Quality Account.
	• Consideration to be given to whether there should be a Governor Indicator for audit. The Committee had requested that the Director of Nursing work with them to identify indicators that would be of value to the existing set of indicators. The Committee recommendations would be brought to the full Council in due course.	

	Questions/comments were invited: • PD suggested that sepsis could be the additional indicator. He undertook to send video links on sepsis to the Council. • PBa noted that a statement indicating that the risk management and learning from incidents in the Urgent Care and Long Term Conditions was under-developed had appeared in the Grant Thornton reports. He suggested that an auditable schedule of incidents could be drafted. This could be considered as the additional indicator. • DB suggested auditing "normalising the abnormal metrics" as the Trust struggled to meet demand. **DECISION:** The Council **agreed** that the Council of Governors Quality Committee would ask the Director of Nursing to work with them to agree in the indicator for proposal to Council.	
	Workforce There was no discussion on this item.	
	Audit and Governance Questions/comments were invited on the Audit and Governance Committee paper: • ML recalled that voting rights would be outlined in the Terms of Reference. It was noted that this had not been added. An action was set for this to be done. • Training from auditors had not been arranged. This was set as an action for AB. • AB provided clarification on the discussions that had been held in relation to car-parking fraud. DECISION: The Council approved the recommendation that the contract with external auditors be extended for a further two years. DECISION: The Council ratified the Terms of Reference with the understanding that voting rights would be added.	AB AB AB
	Governor Development Workshop – feedback PW provided an overview of the Governor Development Workshop as follows: • ID badges had been produced at St Thomas' that were clearly visible. PW suggested East Kent could consider doing the same. • He noted the work that was being done with the Elderly Care rapid response team. • He reported that CQC had attended the workshop. • It had been reported that the Oxley Trust allowed Governors to attend Part 2 of Trust Board meetings with access to papers to be returned at the end of the meeting; and also to act as observers on Policy Board meetings and Quality and	

	Safety walkabouts. NOTE: The Council of Governors noted the feedback from the Governor Development Workshop.	
65/16	**QUESTIONS FROM MEMBERS OF THE PUBLIC** There were no members of the public present.	
66/16	**ANY OTHER URGENT OR IMPORTANT ITEMS** PW thanked RE for his contribution to the Trust and wished him well for his future. RE gave a brief speech about his time at the Trust and advised the Council that he would continue to take a keen interest at the organisation. It was noted that the 2017 Council Meetings were held on the same day as End of Life Board, which would make it difficult for Governors to attend both.	
67/16	**DATES OF FUTURE MEETINGS** Schedule appended to agenda; venues to be confirmed.	

Date of next meeting: the next meeting of the full Council was scheduled for 30 March 2016

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS MEETING (PUBLIC) – 30 MARCH 2017

ACTION POINTS FROM THE COUNCIL OF GOVERNORS MEETING (PUBLIC) HELD ON 24 NOVEMBER 2016

MINUTE NUMBER	DATE OF MEETING	ACTION DESCRIPTION	LEAD	DUE BY	PROGRESS
OUTSTANDING ACTIONS FROM PREVIOUS MEETINGS					
52/16	05.09.16	An update to be provided on the Matron Review.	CT	When completed	Report not yet presented within the Committee structure. **Ongoing**
ACTIONS FROM THE LAST MEETING HELD					
56/16	24.11.16	**Chair's introduction:** Provide written answers to the questions raised by John Sewell.	NC	N/A	Overtaken by events. **Completed**
59/16	24.11.16	**Matters arising:** Provide a summary on the current state of the Trust's CIPs programme.	MK	ASAP	Report sent 1 December 2016. **Completed**
61/16	24.11.16	**Annual review of register of interests and Fit and Proper Persons declaration:** Outstanding declarations of interest to be provided as soon as possible.	Governors	ASAP	All returns provided. **Completed**
62/16	24.11.16	**Elections 2017 – Update:** Identify Council election preclusions and advise the Council of Governors of the findings.	AF	ASAP	To be confirmed. **Ongoing**
64/16	24.11.16	**Reports from Committees – Finance and Performance:** Council to be provided with further information, via IAGC, on timescales to improve the BAF system and a process to complete the report properly.	AB	ASAP	To be reported through CoG AGC meetings. **Completed**
64/16	24.11.16	**Reports from Committees – AGC:** voting rights to be added to the terms of reference.	AB	ASAP	Updated. **Completed**
64/16	24.11.16	**Reports from Committees – AGC:** training to be arranged from the auditors.	AB	ASAP	Liaising with KMPG. **Ongoing**

REPORT TO:	**COUNCIL OF GOVERNORS' MEETING**
DATE:	**30 MARCH 2017**
SUBJECT:	**QUARTERLY DISCUSSION WITH NHSI**
REPORT FROM:	**MICHÈLE LOW**
PURPOSE:	**To Note**

BACKGROUND AND EXECUTIVE SUMMARY	
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
RECOMMENDATIONS AND ACTION REQUIRED: The Council is asked to note this report.	

Note of telecon Michèle Low, Paul Bennet NHSI
1st February 2017

(Paul is Victoria Keilthy & Suzanne Cliffe's boss)

Paul:
NHSI was visiting the Trust last week to investigate finance. They will make their recommendations informally within NHSI at the end of this week, together with setting out all the considerations for a decision, which will go to a formal committee mid February and consideration by NHSI's Board.

EKHUFT finds itself in difficult and unique circumstances in that it is the first Trust where NHSI is not automatically accepting the recommendations from CQC. There are a number of organisations in Financial Special Measures. But the Regulator is therefore stepping carefully and with consideration if they don't accept CQC recommendations, and have to take account of the political environment also, where the financial situation and performance in urgent care are of critical importance to ministers.

NHSI recognises that improvements have been made, and are looking for sustainable changes. They don't expect the Trust to a return to full financial health, but they want all improvements to be sustainable. A&E / urgent care performance is of considerable concern to NHSI, and they have to feel confident that it will improve.

Because these two issues are of critical importance, the Trust's status will be decided by NHSI Board. The Board will look at what possible benefits there might be for the Trust to retain special measures status, or the benefits to losing this status. There is a lot of NHSI corporate anxiety around how to deal with Trusts like ours, and any decision will not be taken lightly but will be in the political context.

Happy to fix regular quarterly telecons.

Michèle:
The Trust is not alone in experiencing extreme financial pressures, but has a unique environment in the Kent peninsular which costs more to run than many other regional areas, finds it more difficult to recruit staff, and has a problematic estate spread out across a wide area.

Special measures continues to be unnecessarily punitive, affecting staff morale and inhibiting recruitment to senior medical positions as well as other roles, and making our staffing situation more difficult and expensive than it need be.

We are very receptive to advice and help, but don't need the special attention that special measures brings: we know what we're doing and we believe that the structural and practice changes made will be sustainable.

Paul's advice:
NEDs and Council would do well to focus on sustainable improvement and the urgent care position which is worrying NHSI and is as much of a problem as the financial side.

REPORT TO:	**COUNCIL OF GOVERNORS' MEETING**
DATE:	**30 MARCH 2017**
SUBJECT:	**QUARTERLY DISCUSSION WITH NHSI**
REPORT FROM:	**MICHÈLE LOW**
PURPOSE:	**To Note**

BACKGROUND AND EXECUTIVE SUMMARY	
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
RECOMMENDATIONS AND ACTION REQUIRED: The Council is asked to note this report.	

Note of telecon Michèle Low, Paul Bennet NHSI
1st February 2017

(Paul is Victoria Keilthy & Suzanne Cliffe's boss)

Paul:
NHSI was visiting the Trust last week to investigate finance. They will make their recommendations informally within NHSI at the end of this week, together with setting out all the considerations for a decision, which will go to a formal committee mid February and consideration by NHSI's Board.

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The Trust is not alone in experiencing extreme financial pressures, but has a unique environment in the Kent peninsular which costs more to run than many other regional areas, finds it more difficult to recruit staff, and has a problematic estate spread out across a wide area.

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We are very receptive to advice and help, but don't need the special attention that special measures brings: we know what we're doing and we believe that the structural and practice changes made will be sustainable.

Paul's advice:
NEDs and Council would do well to focus on sustainable improvement and the urgent care position which is worrying NHSI and is as much of a problem as the financial side.

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**30 MARCH 2017**
SUBJECT:	**TRUST STATUTORY DECLARATION TO NHS I - process**
BOARD SPONSOR:	**TRUST SECRETARY**
PAPER AUTHOR:	**TRUST SECRETARY**
PURPOSE:	**INFORMATION**
APPENDICES	**None**

BACKGROUND AND EXECUTIVE SUMMARY

Provider Licence

The Health and Social Care Act 2012 (the Act) made changes to the way NHS service providers were regulated, and gave Monitor (now NHS Improvement) new duties and powers. These changes included the introduction of the Provider Licence. All foundation trusts were issued with a licence from 1 April 2013.

The standard licence conditions are grouped into six sections:

- General Conditions
- Pricing Conditions
- Choice and Competition Conditions
- Integrated Care Condition
- Continuity of Service Conditions
- Foundation Trust Conditions

In August 2014 Monitor (now NHS Improvement) found the Trust to be in breach of the following provisions of condition FT4 - FT4 (4)(b & c); FT4(5)(a – c, e,f); FT4(6)(c-f); FT4(7) of its Provider Licence; in July 2015 Monitor found the Trust to be in breach of the following provisions of CoS3(1), FT4 5(a) (see above) and FT4 5(d) of its Provider Licence. This is reflected in its Annual Governance Statement within the Annual Report.

All foundation trusts have to submit two annual self-declarations in relation to:

- General Condition 6 - Systems for compliance with licence conditions and related obligations – due by 31 May 2017; and
- The Corporate Governance Statement which reflects the "Foundation Trust Conditions (FT)" on governance – due by 30 June 2017. In addition this declaration also requires the Trust to make a declaration about any major joint ventures it is involved in and to confirm that it has provided adequate training to its Governors.

Last year the Trust's declarations were made on time and they reflected the licence breaches.

The process for 2016/17

The Trust Secretary is working with NHS Improvement to seek a review of the current undertakings and is in the process of gathering relevant evidence. This may reduce the number of licence breaches.

During March and April 2017 the Board Committees will review the Licence Conditions and

seek assurance over the evidence in place to demonstrate compliance, this will flow through to the Board through Chair reports.

The content of the self-assessments will reflect the work on governance that has taken place over the last year and refer to the Well-Led Review, the CQC Reports and the Board and Council of Governor effectiveness reviews.

Both self-certifications will be presented to the May Council of Governors meeting, in private session, for Governors views for consideration by the Board prior to final sign-off.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	None
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	None
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	

PRIVACY IMPACT ASSESSMENT: No	**EQUALITY IMPACT ASSESSMENT:** No

RECOMMENDATIONS AND ACTION REQUIRED:

(a) Note the process for the Provider Licence self-certification process for 2016/17.

REPORT TO:	**COUNCIL OF GOVERNORS' MEETING**
DATE:	**30 MARCH 2017**
SUBJECT:	**GOVERNOR TRAVEL AND EXPENSES POLICY**
REPORT FROM:	**AMANDA BEDFORD** **GOVERNOR AND MEMBERSHIP LEAD**
PURPOSE:	**TO AGREE**

BACKGROUND AND EXECUTIVE SUMMARY

The review date for this policy is March 2017. Two substantive changes have been made:

1. Clarifying that payment will only be made when receipts, or copies thereof, are provided with the claim; and
2. Removal of the requirement included in the current policy document for expenses to be claimed within one month.

   No maximum claim period has been included; however, Governors are asked submit claims on a regular basis and not to hold them for long periods.

The other changes made to the policy are grammatical or to update following staff structure changes.

A copy of the policy will be circulated to all Governors when it has been approved by the Policy Group.

LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.

RECOMMENDATIONS AND ACTION REQUIRED:

The Committee is asked to note the substantive changes to the policy and that copies of the finalised document will be circulated to all Governors.

REPORT TO:	**COUNCIL OF GOVERNORS' MEETING**
DATE:	**30 MARCH 2017**
SUBJECT:	**COUNCIL OF GOVERNORS' REGISTER OF INTERESTS**
REPORT FROM:	**ALISON FOX** **TRUST SECRETARY**
PURPOSE:	**TO NOTE**

BACKGROUND AND EXECUTIVE SUMMARY

The Trust's Constitution requires that there be a register of interests of governors (Section 38 Registers), that it be validated annually (Section 39) and that it be made available for public inspection (Section 40).

A copy of the register is attached which has been updated to take into account the changes following the 2017 elections. This will be linked onto the Trust's website following the meeting.

Governors are asked to advise the Trust Secretary as soon as possible if there are any changes to their declared interests.

LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.

RECOMMENDATIONS AND ACTION REQUIRED:

The Council is asked to note the updated register of interests.

Governors are asked to note the request to advise the Trust Secretary as soon as possible if there are any changes to their declared interests

REGISTER OF COUNCIL OF GOVERNOR INTERESTS 2016/17

NAME AND CONSTITUENCY	TERM ENDS	INTERESTS DECLARED	NOTES
ANDREWS, SARAH Elected (Dover)	28 FEBRUARY 2018	Nursing First Consultancy (Dormant) **(2)** Member CCG East Kent Respiratory Pathway Development Group **(5)** Member, CCG East Kent Respiratory Network Member British Lung Foundation (BLF) **(5)** Member Scleroderma and Raynaud's Association (SRUK) Fellow, The Queen's Nursing Institute **(5)** Patient Member, Royal Free London NHS Foundation Trust **(5)** Patient Member, End of Life Care Committee and Patient Advisory Committee, Royal Brompton and Harefield Foundation Trust **(5)** Patient Member Royal Brompton and Harefield Foundation Trust Respiratory Development (Rebuild) Group **(5)**	Elected March 2015 (1st Term)
BARTLETT, PAUL	12 FEBRUARY 2018	British land Investments **(1)**	Elected Mid Term October 2015

NAME AND CONSTITUENCY	TERM ENDS	INTERESTS DECLARED	NOTES
Elected (Ashford)		Member, Ashford Borough Council **(5)** Member, Conservative Party **(6)** Bank of York Mellon **(1)** Member, South Coast Ambulance Foundation Trust **(5)** Member, East Kent Community Health NHS Trust **(5)**	(1st Term)
BOGARD, DAVID Elected (Staff)	29 FEBRUARY 2020	None	Elected March 2017 (3rd Term)
BULL, PHILIP Elected (Shepway)	28 FEBRUARY 2018	Work for Spire, St Saviours Hospital **(4)** Involved in Deal Rheumatology Pilot Project **(5)** The IQ Clinical Leadership program (non-promotional, educational only) funded by Pfizer. **(5)** Voluntary work for The Hypermobility Syndromes association charity. **(4)** Medical education for the Trust Junior Doctors (sessional remuneration, not on payroll) **(5)** Rheumatology Education for South Kent Coastal and Canterbury CCGs PLT program (nominal remuneration, occasionally funded via pharma on a non-promotional	Elected March 2015 (1st Term)

NAME AND CONSTITUENCY	TERM ENDS	INTERESTS DECLARED	NOTES
		basis) **(4)** Private clinics performed at the One Hospital Ashford and the Chaucer Hospital Canterbury and at Oaklands Health Centre Hythe. **(5)** Medical Advisor to the Hypermobility Syndromes charity **(4)**	
CARLIELL, MANDY Elected (Staff)	29 FEBRUARY 2020	None	Elected March 2017 (3rd Term)
CURD PAUL Elected (Dover)	29 FEBRUARY 2020	Trustee of Carers' Support – Canterbury, Dover and Thanet **(4)** Healthwatch volunteer **(5)** Member of the Liberal Democrat Party **(6)**	Elected March 2017 (1st Term)
DAVIES, GERAINT Partnership (South East Coast Ambulance NHS Foundation Trust)	28 FEBRUARY 2018	None	Nominated March 2012 (2nd Term)

NAME AND CONSTITUENCY	TERM ENDS	INTERESTS DECLARED	NOTES
DEXTER, ROY Elected (Thanet)	28 FEBRUARY 2017	Trustee CT10 Parochial Charities **(4)** Member of the Conservative Party **(6)**	Elected March 2017 (2nd Term)
DURKIN, PAUL Elected (Swale)	28 FEBRUARY 2018	Member of Friends of Faversham Cottage Hospital and Community Health Centres **(5)** Member of South East Coast Ambulance Foundation Trust **(5)** Member of local GPs Patient Participation Group (PPG) **(5)** Member of the Labour Party **(6)**	Elected March 2015 (2nd Term)
GODDARD, ROBERT Elected (Staff)	28 FEBRUARY 2018	National Health Service Blood and Transplant Regional Transfusion Committee **(4)**	By-Election May 2015 (1st Term)
HARRIS CAROLINE Elected (Ashford)	29 FEBRUARY 2020	Member of Healthwatch Kent **(5)** Chair, Ashford South Community Network – Ashford CCG **(5)** Chair, Sellindge Surgery PPG **(5)**	Elected March 2017 (1st term)
HOLMES ALAN DR	28 FEBRUARY 2018	None	By-election Feb 2016

NAME AND CONSTITUENCY	TERM ENDS	INTERESTS DECLARED	NOTES
Elected (Canterbury)			(1st term)
LAING, MARGO Elected (Dover)	28 FEBRUARY 2017	Member of CCG Services Development Group for South East Coast CCG **(4)** EOL Workstream for South East Coast CCG **(4)** Secretary, League of Friends of Victoria Hospital, Deal **(4)**	By-Election May 2015 (1st term)
LOW MICHELE Elected (Shepway)	28 FEBRUARY 2018	Member Independent Monitoring Board (Dover) **(4)** NED The Abbeyfield Kent Society (1) Responsible Finance Officer & Treasurer, Stowting Parish (6, Independent)	Elected December 2015 (1st Term)
LYONS, MICHAEL JOHN ANTHONY Partnership (Volunteers Working with the Trust)	28 FEBRUARY 2018	Trustee of Friends of William Harvey **(4)** Member of the Conservative Party **(6)**	Nominated March 2012 (2nd Term)
LYONS-BACKHOUSE EUNICE Elected (Rest of England and Wales)	28 FEBRUARY 2018	Member of Medway NHS Foundation Trust **(4)** Member of Maidstone and Tunbridge Wells NHS Foundation Trust **(4)**	Elected March 2015 (2nd Term)

NAME AND CONSTITUENCY	TERM ENDS	INTERESTS DECLARED	NOTES
RAMPTON JOHN DR Elected (Staff)	25 FEBRUARY 2017	Trustee Ashford Counselling Service **(4)**	Elected End October 2015 (1st Term)
SEWELL, JOHN Elected (Shepway)	28 FEBRUARY 2017	Chair – Ashford Health Education Foundation **(5)**	Elected March 2014 (2nd Term)
TEASDALE, DEBRA Partnership (Canterbury Christ Church University and University of Kent)	28 FEBRUARY 2018	Dean of Health and Wellbeing, Canterbury Christ Church University **(1)**	Nominated 1 November 2014 (1st term)
WARBURTON, MARCELLA Elected (Thanet)	28 FEBRUARY 2017	None	Elected March 2017 (2nd Term)
WARRICKER CHRIS	28 FEBRUARY 2018	Member of the Conservative Party **(6)**	By-election Feb 2016

NAME AND CONSTITUENCY	TERM ENDS	INTERESTS DECLARED	NOTES
Elected (Canterbury) Previously Ashford Governor			(1st term)
WELLS , CHRIS Partnership (Representing 6 Local Authorities in East Kent)	28 FEBRUARY 2018	Director E.K.O **(1)** Self Employed Management Trainer/Consultant **(2)** Member of the UKIP **(6)**	Nominated October 2016 (1st term)
WELLS, PHILIP Elected (Canterbury)	28 FEBRUARY 2017	None	Elected March 2017 (3rd Term)
WESTCAR-JARRETT, REYNAGH Elected (Thanet) nee JARRETT, REYNAGH	28 FEBRUARY 2018	Member of HealthWatch **(4)** Member of SECAMB **(5)**	Elected March 2012 (2nd Term)
WHORWELL, JUNETTA Elected (Ashford)	28 FEBRUARY 2017	Member of the East Kent Community Health NHS Trust **(5)** Patient Representative of East Kent Community Health NHS Trust Patient Experience Committee **(5)** Member of HealthWatch **(4)** Member of the Patient Participation Group – Ashford GP **(5)**	Elected March 2017 (3rd Term)

NAME AND CONSTITUENCY	TERM ENDS	INTERESTS DECLARED	NOTES
		Member of South East Coast Ambulance Foundation Trust **(5)** Member of Kent and Medway Social Care Partnership Trust **(5)** Trustee on the Weald of Kent Vocational Training charity **(4)**	
WILLIAMS, MATT Elected (Swale)	28 FEBRUARY 2018	None	Elected March 2015 (2nd Term)

Categories:

1 Directorships

2 Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS

3 Majority or controlling shareholding

4 Position(s) of authority in a charity or voluntary body

5 Any connection with a voluntary or other body contracting for NHS services

6 Membership of a political party

REPORT TO:	**COUNCIL OF GOVERNORS' MEETING**
DATE:	**30 MARCH 2017**
SUBJECT:	**REPORT FROM THE CoG MEMBERSHIP, ENGAGEMENT AND COMMUNICATIONS COMMITTEE**
REPORT FROM:	**MATT WILLIAMS COMMITTEE, CHAIR**
PURPOSE:	**Discussion**

BACKGROUND AND EXECUTIVE SUMMARY

The CoG Membership Engagement and Communication Committee have met on three occasions since the last Full Meeting of the Council, so this is a lengthy report; meetings were held on 1 December 2016, 17 January and 15 March 2017. This report provides the Council of Governors with an update on the issues covered and makes recommendation for consideration by the Council.

The key item of business included:

- Recent Governor elections
- Our New NED
- Charitable Funds Committee report
- Strategy timeline
- Member email acquisition
- Your Hospital magazine
- Meet the Governors (MTG)
- The AMM
- E-newlsetter
- EKHUFT charity
- Representative membership
- Social media
- Membership feedback
- Membership recruitment flyer

LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.

RECOMMENDATIONS AND ACTION REQUIRED:

The Council is asked to:

- note and agree the new MtG guidance and resource;
- consider receiving a presentation from the charity about the dementia village; and
- agree the changes to the membership leaflet.

Chair's overview

As there have now been three MECC meeting since the last full CoG, please excuse the length of this report; there is much to cover.

Firstly to say that the commitment and time given by my fellow governors as members of the MECC has been, I feel, time well spent. The meetings and the numerous emails, phone conversations, 'corridor conversations' and discussions which have taken place over the last few months between meetings have all assisted in moving our work forward. Also the time and commitment of the governors' staff support and senior executives has allowed the Committee's activities to begin to 'gain traction' within the trust.

As Chair of the MECC I attempt to allow our meetings to not only address agenda issues and take decisions that need to be made - then passed up with a recommendation to the full CoG but - but with time allowing, for some discussions to follow their natural course. That has given us the chance to develop and flesh out some aspects of the agreed Membership and Communications Strategy that the CoG adopted on last year.

The Committee has continued to focus its work on implementing the agreed strategy and continues to benchmark its activities against this document.

The key items covered over the three meetings include the following.

Recent Governor Elections.

At the meeting on 15 March the Committee received a report on the recent Governor Elections, which is at Annex A.

Our new NED

Following the resignation from the Trust Board of Gill Gibb, Keith Palmer joined the trust and was given the task of attending MECC meetings. I have had a couple informal meetings with Keith to 'bring him up to speed' with the Committee and its work. His input at the last couple of meetings has been invaluable and the Committee has been kept informed of any Board activity that may have an indirect or direct effect on the work we do. In turn the Committee has been able, through Keith, to hold the Board accountable for areas covered by the MECC.

Charitable Funds Committee report

The MECC receives a report on the activities of the Trust's Charitable Funds Committee, chaired by Keith Palmer. Keith reported on the recent allocations of funding agreed by the Committee. For some time the Committee has been driving income faster than it has spent it, but a new strategy, which is in line good governance, has been adopted to allocate the funds as quickly as possible and reduce the charity's reserves to 3 months.

It is worth noting that the Charity fundraising manager is regular attendee of the Committee and who contributions are highly valued in aiding in our work.

One item the MECC felt would be useful for the full CoG to see was a presentation given by the Charity Fund Raising manger about the proposed dementia village.

Strategy Timeline

The Committee continues working on a formal timeline for the implementing the Strategy – in parallel to action both key sections and the more 'low hanging fruit' parts of the strategy.

Member email acquisition

One issue which is ongoing and no easy task is the collection of emails from members. As I have stated in past reports, the trust can simply not afford to post out thousands of copies of the newsletter – and even if it could it would be a struggle to justify that's what money should be spent on. Though we have the emails for all staff members, sadly we only have around 4000 (about 40%) for public members. We are hoping to, over time, collect as many of the remaining 60% as we can. So far we have made a request for members to be asked to provide an email address in the trust's magazine and are working on including this on all trust communication with members and a shout out on the trust's social media. Emails are also being collected from all new members.

Your Hospital – the magazine of EKHUFT

The Committee has been asked to impute into the content of the magazine, specificity the 'Governors/Members' page. We have encouraged the editor, who has been totally supportive, to add governor profiles, MtG information and news about the Governor elections and the Annual Members' meeting.

Meet the Governors (MTG)

As referred to in my last report, the new tools for governors who undertake MtG sessions are now in place and have been tested at two MtG sessions and one public meeting. Additionally we have been given pens and shopping trolley tokens by the EKHUFT Charity to use for thanking people for talking to us. The 'survey' type form aims to give governors a 'reason' to approach members of the public, as some find it difficult to just approach people and start talking. This, together with a crib sheet, is something we hope the CoG will agree to use at all MtG sessions. It has also been recommended that theses 'survey' forms include a freepost return address to allow people to fill in once home.

MtG on site sessions for this year are now in the diary.

MtG attendance at public events will be ad hoc as opportunities come up and these will include public engagement sessions that the Trust's Communication team is setting up through the year - such as the recent public meeting discussing diabetes, organized jointly be EKHUFT and KCHC where Junetta and Philip Wells set up a 'meet the governor' table.

The AMM

As outlined in my recent email, the date has been confirmed as 7 September. As I said in that same email the Committee will be working with the Communications team to build on past AMMs both in terms of activities and information provided at the event and also in encouraging greater participation from our membership.

e-Newsletter

We have now published two Governors newsletters to members and it is slowly developing into a constructive way for governors to communicate on issues to the members. Though for the first couple we relied only on news provided directly from the trust, as things move we hope there will be more content from those at this meeting. So far we have covered issues such as the STP, governor elections and volunteering,

I would urge governors to let myself know if they wish to include something in the newsletter. This publication is all about governors talking to members so if you have event dates, or simply something you feel it is worth bringing to the attention of members this is the place for it. The MECC will continue to act as editorial board

EKHUFT Charity

The EKHUFT charity fundraising manager is a welcome and regular attendee at the MECC. The Committee agreed to, and has, given exposure to the charity through the members newsletter and asked the it to provide a written briefing to for all governors so as to make the aims and objects of the charity clearly understood and allow governors to be able to inform its constituents how they could possibly support its campaigns. The charity has kindly agreed to supply us some of its promotional produces to use as 'thank you' at MtG events.

Representative membership

Further work has been undertaken to analyze the current membership and its comparison with official demographic data. As has been discussed at previous CoG meetings, it is clear that to be truly representatives we need to reach out to socioeconomic groups who, at present, are very much under represented.

This is no easy task as individuals from these groups often have other, and more pressing priorities, but are also more frequent users of our services. We will/have been pro-active in reaching out to organised groups from within these communities and offering to provide governors to address meetings or set up a stand at communities events.

Social Media/WWW

This is one area which is taking time to establish. I think we would agree the trust's use of its public social media has massively improved over the last six months but as yet there has not been the resources to create a 'social media relationship' between governors and members. As we work on the strategy implementation timeline, this is likely to move up the priority list.

The Governor section of the EKHUFT WWW is also still pending completion.

Membership Feedback

At each meeting the MECC looks at the Membership Feedback Data base to see if there are any themes or trends, or if there are any issues which we think need to be looked at by another CoG committee. No themes or trends have been seen yet. At the October meeting we passed an issue around complaint response performance to the Quality Committee and received their response at the December meeting. This provided information from Jane Christmas, Deputy Nursing Director, abouth the Trust's complaint process and staff training on complaints handling.

Membership Recruitment Flyer

The Membership recruitment flyer is going to re-print and the Committee has suggested two changes: a re-ordering of bullet points on the back page 'Why become a member' to highlight involvement; and adding in a section to the application form for members to indicate if they have any access needs ie hearing loops or wheelchair access. Governors are invited to raise any further suggestion with myself or Amanda prior to the CoG meeting

ANNEX A

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**CoG MEMBERSHIP ENGAGEMENT AND COMMUNICATIONS COMMITTEE**
DATE:	**15 MARCH 2017**
SUBJECT:	**2017 GOVERNOR ELECTION RESULTS**
REPORT FROM:	**AMANDA BEDFORD GOVERNOR AND MEMBERSHIP LEAD**
PURPOSE:	**To note**
EXECUTIVE SUMMARY This report provides a brief summary of the 2017 Governor Elections.	
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision**: provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
RECOMMENDATIONS AND ACTION REQUIRED: The Committee is asked to note the contents of this paper and provide a summary to the Full Council via the Chair's report.	

BACKGROUND

The terms of seven Governors came to an end on 28 February 2017 and the elections to the vacancies were held over January and February 2017, with the results declared on 27 February.

Information about the vacancies was publicised on the Trust's website, via email directly to members and in the Trust's magazine. Three information sessions were held for those interested in standing for election; one at each of the three main sites. These were not well attended.

RESULTS

The results of the elections were as follows:

Non-contested:
Ashford: Junetta Whorwell and Caroline Harris declared
Dover: Paul Curd declared

Staff: Mandy Carliell and David Bogard declared

Contested:

Constituency	Candidates	Votes	Total votes case	Electorate	Turnout
Canterbury	Philip Wells (elected)	190	308	4620	6.7%
	Graeme Sergeant	116			
Shepway	John Sewell (elected)	180	204	1718	11.9%
	Terry Mullard	23			
Thanet	Marcella Warburton (elected)	181	257*	3722	6.9%
	Roy Dexter (elected)	112			
	Stuart Alexander	85			
	Mike Pearce	80			

* This is not the sum of the votes as members were able to vote for two candidates.

This was the second year when members were able to vote electronically. The table below provides a breakdown of the proportion voting by post and electronically.

2017

Constituency	Quantity Mailed	Quantity Emailed	Quantity Returned By Post	Quantity Returned By Internet / Text Message	Total Returned	Turnout %
Shepway	728	276	127	77	204	20.32%
Thanet	1519	700	151	106	257	11.58%
Canterbury	1668	1,365	188	120	308	10.15%

2016

Constituency	Quantity Mailed	Quantity Returned By Post	Quantity Returned By Internet / Text Message	Turnout %
Dover	1,469	203	61	17.97%
Ashford	1,132	165	13	15.72%
Shepway	951	148	53	21.14%

ELECTION ISSUES

As part of the election process the Trust provides the data to UK Engage for them to send out ballot papers. During the election it was reported that one member had received two ballot packs with different unique identify numbers. An investigation was carried out to determine how this had happened with the following conclusion:

- The root cause resulting in the issue of two unique voting numbers to the same member was established – failure to run the database duplication report prior to providing the data to UK Engage. This is a report which identifies where the details of two members suggest that they may be the same person.
- The duplication report was run and showed 31 confirmed duplications - 0.28% of the overall electorate.
- 13 of the duplications were shown not impact on the integrity of the elections.
- 18 had a potential impact and UK Engage confirmed that in each case action could be taken to ensure that the members involved could only vote once.
- The UK Engage returning officer confirmed that if the suggested actions were taken the integrity of the election would be maintained.
- The Trust's Internal Auditors were in agreement if it could be confirmed that all potential duplicates had been identified and the Board was comfortable that there were no further anomalies with the data

This was reported to the public Board meeting on 8 February and it was agreed that the election had not been compromised.

The Trust was also advised that some members who were expecting to receive ballot papers had not. Enquiries were made and showed that the ballot papers had been sent electronically and the members involved had changed their email address since joining or the ballot email had been filtered as spam. In addition, in early 2016 the membership database had been migrated to a new version and it transpired that in doing so some members had been moved onto 'email only' contact list.

To remove the risk that some members would not be aware that they had the opportunity to vote, a postal ballot letter was sent to all members in the contested constituencies who were on the email only list. This provided members with an opportunity to vote either by post or electronically.

LESSONS LEARNED

A full de-briefing following the elections is planned for 28 March. Points which have been noted already are:

- The contract for the membership database provider allows for them to prepare and provide the personal data to the election provider – this service will be used in the future.
- The pre-election publicity making members aware of the elections and encouraging candidates to stand needs to be revised and renewed.
- An exercise needs to be undertaken to confirm the robustness of the 'email only' list.

MEMBERSHIP DATABASE

The membership database provider has informed the Trust that it is pulling out of the market and has suggested that the contract is taken over by Membership Engagement Services (MES). They are the leading provider in this sector and, based on previous experience with their software, the product is superior to the current provider. Procurement are involved in the contractual elements of the move and it is intended to take time on the 28 March to plan for the migration, including consideration of any be-spoke features the Trust would like to add to the database.

Committee Chair's Overview

Key items of Business

Recommendations

Next Steps

East Kent Hospitals University NHS
NHS Foundation Trust

CoG 6a/17

CIPS UPDATE
Month 11 (February 2017)

We care

Key Messages

East Kent Hospitals University NHS
NHS Foundation Trust

- CIPS plan 16/17 £20m
- Year to date reported £16.9m v £17.7m plan including £3.8m income
- Forecast c£19m of which c£4m non recurrent
- Challenges:
  - Workforce and service pressures impact ability to generate pay savings (£3.7m)
  - Operational bed pressures impact ability to increase theatre efficiency (£2.4m) and generate LoS savings (£0.2m)
  - Outpatient scheme cost reduction not progressed (£0.9m)
  - Status of CQC special measures
- Lessons for 2017/18
  - Start earlier (Mark Hackett in since December 2016)
  - Senior commitment and programme resources
  - Focused project plans – milestones, resources, accountability
  - Clinical engagement
  - Timely escalation and reporting
  - Taking the 'difficult' decisions
- Target 2017/18 £30m with £23m identified to date

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Month 11 CIPS

East Kent Hospitals University NHS
NHS Foundation Trust

East Kent Hospitals University NHS
NHS Foundation Trust

Cost Improvement Summary

Month 11 (February) 2016/17

Delivery Summary	Year to Date			This Month			Forecast	
Programme Themes £000	Plan	Actual	Variance	Plan	Actual	Variance	Outturn	Variance
Theatres	3,518	1,165	(2,353)	242	-	(242)	1,487	(1,642)
Outpatients	898	-	(898)	127	-	(127)	-	(500)
Patient Flow/LOS	295	71	(224)	16	9	(7)	119	(281)
Diagnostic Demand Reduction	-	-	-	-		-	-	(300)
Agency	96	1,899	1,803	-	297	297	2,086	(2,110)
Workforce *	7,509	1,964	(5,545)	942	356	(586)	2,125	(1,976)
Procurement	2,153	2,283	129	204	237	33	2,561	(439)
Medicine Optimisation	803	587	(216)	62	54	(8)	628	(972)
Division Schemes **	2,440	5,109	2,669	484	1,340	856	5,760	2,986
Sub-total	**17,712**	**13,078**	**(4,635)**	**2,077**	**2,293**	**216**	**14,766**	**(5,234)**
Income Completeness	-	3,779	3,779	-	578	578	4,374	4,374
Grand Total	**17,712**	**16,856**	**(856)**	**2,077**	**2,871**	**794**	**19,140**	**(860)**

** Includes all workforce related schemes in divisions*

*** Smaller divisional schemes not allocated to a workstream*

Delivered £000		
Month	Target	Actual
April	656	517
May	670	791
June	1,122	902
July	1,703	857
August	1,658	845
September	1,608	1,953
October	2,048	1,242
November	2,069	988
December	2,025	1,186
January	2,077	1,503
February	2,075	2,293
March	2,288	
**excl Income Completeness*	**20,000**	**13,078**
		65.4%

CIPs

M11 YTD delivery (excl income schemes) was £13.1m against plan of £17.7m. The shortfall of £4.6m includes theatre efficiency £2.4m, outpatients £0.9m and workforce/agency £5.4m, mitigated by overperformance in the month of divisional schemes of £2.7m. Theatres variance is due to the impact of an overall shortfall in income against plan in surgical specialties. Income CIPs related to activity over-performance have delivered a contribution of £3.8m YTD. The additional activity has been delivered by increased efficiency whilst containing the cost base. FY16-17 CIPs plans total £19.1m (gross) or £18.9m (risk adjusted) against the £20m target.

Month 11 CIPS

East Kent Hospitals University NHS
NHS Foundation Trust

Planned Summary	2016 - 2017			Target Variance	
Programme Divisions £000	Draft Target	Gross	RAG Adj	vs Gross	vs RAG
Clinical Support	2,191	2,090	2,081	(101)	(109)
Specialist	1,220	1,682	1,682	462	462
Surgery	5,869	1,897	1,791	(3,972)	(4,077)
UC&LTC	3,843	1,328	1,315	(2,515)	(2,528)
Corporate - Other	1,507	2,693	2,693	1,186	1,186
SD&CP	600	1,419	1,390	819	790
Procurement	3,000	3,029	2,999	29	(1)
Medicine Optimisation	1,600	628	628	(972)	(972)
Outpatients	-	-	-	-	-
Workforce	171	-	-	(171)	(171)
Sub-total	**20,000**	**14,766**	**14,579**	**(5,234)**	**(5,421)**
Income Completeness		4,374	4,374	4,374	4,374
Grand Total	**20,000**	**19,140**	**18,954**	**(860)**	**(1,046)**

Planned Summary	2016 - 2017			Target Variance	
Programme Themes £000	Draft Target	Gross	RAG Adj	vs Gross	vs RAG
Theatres	3,129	1,487	1,407	(1,642)	(1,722)
Outpatients	500	-	-	(500)	(500)
Patient Flow/LOS	400	119	107	(281)	(293)
Diagnostic Demand Reduction	300			(300)	(300)
Agency	4,196	2,086	2,060	(2,110)	(2,136)
Workforce *	4,101	2,125	2,116	(1,976)	(1,985)
Procurement	3,000	2,561	2,531	(439)	(469)
Medicine Optimisation	1,600	628	628	(972)	(972)
Division Schemes **	2,774	5,760	5,730	2,986	2,956
Sub-total	**20,000**	**14,766**	**14,579**	**(5,234)**	**(5,421)**
Income Completeness		4,374	4,374	4,374	4,374
Grand Total	**20,000**	**19,140**	**18,954**	**(860)**	**(1,046)**

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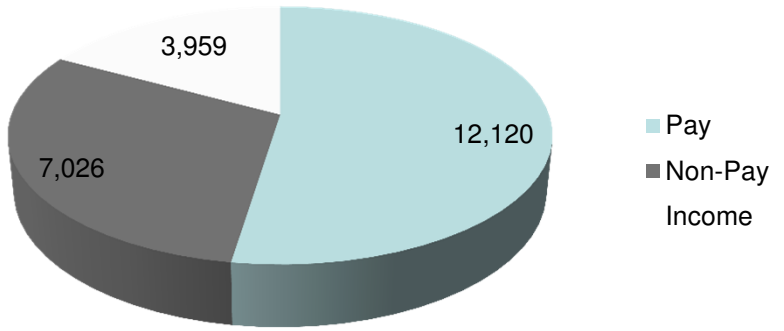
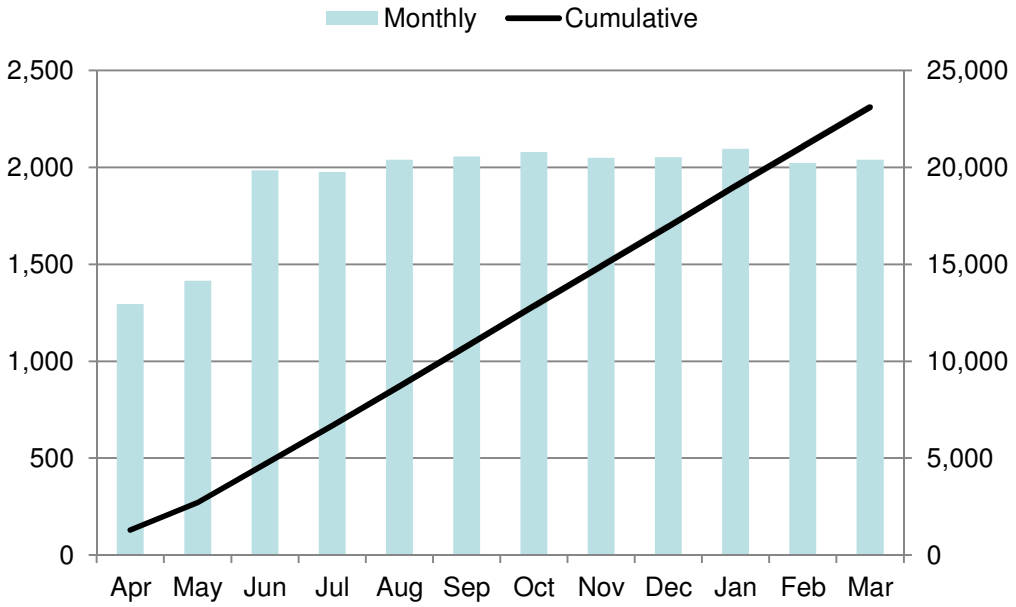
Savings Plans 2017/18 as at 20.03/17

CIP ANNUAL ORIG. PLAN - PROFILED MONTH ON MONTH	Annual Plan £'000
CSSD	1,706
Surgical	6,629
UCLTC	3,260
SDCP	452
Corporate	758
Specialist	1,971
Workforce and Agency	5,929
Procurement	2,400
TOTAL ANNUAL PLAN / PROFILE	**23,105**



Commentary:

- **Schemes still being worked up**
  - **SLR reviews, Agency, Pharmacy, Patient flow**
- **Non-recurrent opportunities not included in above**
  - **Vacancies, Travel**
- **Sessions continuing March through April**



NHS Efficiency Map – NHSI November 2016

East Kent Hospitals University NHS
NHS Foundation Trust

Explanation of terms

Cost savings can be measured using different methodologies. NHS trusts and NHS foundation trusts have previously measured CIP savings on a different basis but NHS Improvement[4] now defines cost savings using the former Trust Development Authority's method, namely by including revenue generation as a saving and using total expenditure as the denominator, rather than total controllable operating costs. We have produced clear definitions for the following different types of efficiency improvement.

Cost reduction means providing a service at the same or better quality for a lower unit cost, through new ways of working that eliminate excess costs. The costs that are reduced could be ongoing or future pay or non-pay expenditure. A simple example is the use of a different orthopaedic prosthesis offering the same or improved clinical quality for a lower unit cost. Cost reduction savings are typically savings that are cash-releasing. Cash can be released on a recurrent, ongoing basis (if, for instance, staff costs are reduced) or a one-off, non-recurrent basis. They differ from non-cash releasing savings, which result in more activity or services for the same cost or for an additional contribution.

Cost avoidance is a type of cost reduction but refers specifically to eliminating or preventing future costs arising. Cost avoidance measures may involve some expenditure but at a lower level than the expected future costs to be avoided. They may typically not formally be part of the CIP programme but instead avoid future cost pressures. Examples are the avoidance of using locum doctors by making substantive appointments, reducing (non-budgeted) premium pay spend, or increased use in the future of nursing bank staff to avoid higher cost agency premium pay.

Income generation This applies to non-NHS contract funding schemes that provide a contribution to an NHS body that can be used for improving health services. Examples include charging for certain patient services or facilities such as a private room and television or telephone. NHS bodies can also enter into commercial ventures with private companies to generate income from specific services. The Department of Health provides further details[5]. Income generation schemes are typically cash generating schemes as opposed to cash releasing cost reduction schemes.

Service productivity improvements These schemes aim to improve patient care by changing the way services are delivered so that productivity is increased and financial benefits can be delivered. Service productivity improvements often involve joint working between clinical, operational and finance staff, sometimes across different organisations, to develop new ways of working.

Improving service quality and safety are the main priority with the intention of identifying on-going, recurrent efficiency savings and productivity gains through delivering services in the best way. These schemes can make cost savings or can generate an additional contribution.

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East Kent Hospitals University NHS
NHS Foundation Trust

Board FPC
CIP Governance
March 2017

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East Kent Hospitals University NHS
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FPC Perspective on CIP Delivery

Some of the challenges with CIPs Delivery

Whilst Nick Gerrard CFO has provided key updates on FY16/17 CIPs achievements and our plans for FY17/18 CIPs, it is pertinent to share some of the key challenges from the viewpoint of Board FPC Governance. This would help put in context the work that is being done on the governance front and what needs to be strengthened throughout FY17/18. Some of the challenges include:

1. Divisional ownership of CIP: Ownership of schemes need to shift from corporate centred control to divisional directors and their respective teams in order to increase delivery success since they are the ones managing day-to-day operations and business profit & loss

2. Delivery Capability & Capacity: there are both capability and capacity gaps at the delivery/execution level of management. Whilst the specifics and nature of these gaps have been identified by the executive team, we would need to move quickly to fill the gaps by placing the right internal talents in the right CIP delivery jobs whilst supplementing with external resources in the next few weeks – early in the new FY17/18. This will give us the chance to deliver on time against monthly savings plans.

3. The need for a trust-wide coordinated transformation programme: improvement initiatives that drive CIPs are currently scattered and not powered by a unifying force and transformation agenda. Unfortunately, the negative impact through lost opportunities will be more apparent in a trust such as ours with several sites and different ways of working and cultures. In order therefore to shift from the perennial CIPs chasing to real transformation of our services, which will yield recurrent CIPs, we urgently need to thoughtfully put together and rollout a compelling trust-wide transformation programme.

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NHS Foundation Trust

FPC Perspective on CIP Delivery

Some of the challenges with CIPs Delivery

4. Need to identify and green-light all CIPs schemes before start of the FY: we have historically not been in a position to identify and green-light projects (i.e. schemes with signed-off project initiation documents PIDs) before the start on a new financial year. This has been in part due to the need for a systematic process and perhaps the somewhat daunting task of making multi-million pounds in-year savings has slowed us down. The eventual full rollout of The Model Hospital benchmarks by NHS Improvement will no doubt strengthen our approach to CIP identification and continuous improvement approach (a key metric that would be very helpful is *cost per weighted activity unit* which will provide robust benchmarks across the entire end-to-end hospital value chain)

5. Comfort around tackling big ticket cost reduction agendas: we need to increase our comfort level around executing on big ticket agendas even if controversial.

6. The need to maximise commercial income opportunities: Until very recently, January 2017, we have historically not capitalized on really driving commercial income opportunities to make up for cost reduction efforts. This should also be part of our CIP programme.

….In summary, whilst these challenges and other factors are part of the reason for financial special measures (FSM), increased governance and management focus to successfully execute needed changes even before FSM is positive. The following slide highlights what additional governance FPC has been put in place and what else is required to be done in FY17/18.

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FPC new governance measures

New Governance Measures Since January 2017

1. Increased accountability of divisions

A regular programme is in place so that one of the four divisions attends FPC each month on a rolling basis giving business updates. What is new since January 2017 is that these presentations are now focused on reporting their biggest challenges to meeting key deliverables including CIPs and what they are doing to recover from any adverse variance. The new structure is:

- ✓ Update on business plan – 10% of time slot
- ✓ Update on run-rate & CIPs delivery – 10% of time slot
- ✓ Key challenges/problems preventing them from achieving business plan, run-rate reductions & CIPs – 30% of time slot
- ✓ Plans to recover from adverse variance – 40% of time slot
- ✓ Support required from Executive Team & Board – 10% of time slot

These monthly presentations therefore provide deep-dives into the most pressing issues, increases opportunity to challenge, offer support and hold divisions and executives to account on delivery. Similar levels of enhanced scrutiny will be required for the financial recovery plan on a monthly basis going forward. This will be the focus throughout FY17/18 as we demonstrate progress in sustainably reducing our income & expenditure run-rate – a key requirement for exiting financial special measures.

It is worth mentioning that April FPC will be fully dedicated to reviewing FY17/18 financial recovery plan in detail. This will then be further reviewed and signed off at the April Trust Board before submissions are made to NHSI in April.

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NHS Foundation Trust

FPC new governance measures

New Governance Measures Since January 2017

2. Trust-wide transformation programme plus addressing capability & capacity gaps

FPC and Matthew Kershaw CEO are in agreement that there is an urgent need to rollout a coordinated trust-wide transformation programme to deliver CIPs & service improvement. To move this forward, FPC has requested a paper on what the architecture of the transformation will look like as well as rollout timeframe. This paper will address

- ✓ Aims, objectives, executive lead & org structure
- ✓ Transformation strategy, methodology and approach
- ✓ Initial scope of work, programme launch & rollout timelines

It is expected that this paper will be provided at the April Trust Board. With regards to addressing delivery capability and capacity gaps, FPC will received a paper on how this is being addressed at the April FPC.

3. Big ticket cost reduction agenda

We are fortunate to have Mark Hackett an experienced NHS Hospital CEO from NHSI working with us as part of Financial special measures on early identification of FY17/18 CIPs. This includes a number of big ticket agenda items. Mark was in attendance at the Feb FPC where he gave full update and provided assurance to the work being done. This will continue into the new FY17/18.

4. Commercial income board

Commercial income board was formed in January 2017 to maximize income opportunities particularly around non clinical areas. We have set a target of 10% increase in commercial income for FY17/18.

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NHS Foundation Trust

Areas of focus going forward

Priority Areas	*Description, Governance & Timeline*	*Who*
Trust-wide Transformation Programme	• Urgently develop and rollout a coordinated trust-wide transformation programme through which recurrent CIPs and service improvement can be delivered. • Matthew Kershaw to sponsor a paper articulating transformation architecture, launch date & rollout plan. Paper to be presented at April Trust Board • Source talent with the right skillset and experience externally and internally to fill CIPs & transformation delivery gaps. Paper detailing plan to address this should be submitted to April FPC	• Matthew Kershaw on transformation paper • Trust Board to review and approve transformation plan at April Board • Sandra Le Blanc and Nick Gerrard to co-sponsor paper addressing capability and capacity gaps for CIPs and transformation delivery.
Commercial Income Opportunities	• FPC will review monthly progress against delivery of set target to increase commercial income by 10% in FY17/18.	• FPC • Executives Directors

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Areas of focus going forward

Priority Areas	*Description, Governance & Timeline*	*Who*
Financial Recovery Plan	• It will not be business-as-usual at FPC going forward. FPC agenda and operating cadence will reflect the fact that we are in financial special measures. There will be increased scrutiny of what we have agreed to deliver in our recovery plan. • FPC will be relentless in scrutinising delivery of FY17/18 financial recovery plan with the focused objective of ensuring we are reducing I&E run-rate in a safe and sustainable manner. As such, we will review monthly net savings against costed budgets. We will ask for forecasts against several key metrics including run-rate, income, operating costs, CIPs savings • Divisions will be used as the engine-rooms through which the recovery plans are delivered. As such, request for presentation focused on business plan, run-rate & CIP delivery will continue.	• FPC & Trust Board • Nick Gerrard to provide monthly reports and forecasts against financial KPIs on a monthly basis • Divisional Operations Directors to provide updates on CIPs & I&E run-rates as part of their presentation to FPC.
The entire governance from trust board to FPC as well as the executive management forum should be geared towards ensuring we are working in a safe and sustainable manner to tackle our financial deficit, reduce our I&E run-rate whilst delivering high quality care to our patients and meeting our business obligation to our partners across Kent.		

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REPORT TO:	**COUNCIL OF GOVERNORS' MEETING**
DATE:	**30 MARCH 2017**
SUBJECT:	**REPORT FROM CHAIR OR THE CoG FINANCE AND PERFORMANCE COMMITTEE**
REPORT FROM:	**MICHÈLE LOW , Elected Governor, Shepway COMMITTEE CHAIR**
PURPOSE:	**Discussion**

BACKGROUND AND EXECUTIVE SUMMARY The CoG Finance and Performance Committee met on 7 February 2017 and this report provides the Council of Governors with an update on the issues covered and makes recommendation for consideration by the Council.	
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
RECOMMENDATIONS AND ACTION REQUIRED: The Committee is asked to note and discuss the content of the report.	

DRAFT NOTES: FPC meeting 7 February 2017

Actions arising

The following items recorded as closed should remain open because they had not been resolved, and should appear regularly as future agenda items, with the exception of the item on Turnaround Director:

- Delayed transfers of care: this was a continuing drain on Trust resources
- BAF: no information has been provided on how and when the BAF was to be improved or on the linked FPC risks
- Level of information received: while Council did not require changes to the information it received, this committee was not satisfied with the information provided
- Annual review of Finance and Performance information: there had been no review thus far.
- Turnaround director (TD): a report had been requested from the NED but not provided. SAd (Sunny Adeusi) said that this role was consultative/engaging rather than target/action focussed. Monitor had required this appointment to be made. The outcome from the time the TD had been in post could not be translated into a financial value, or its quantitative impact on CIP performance measured. The legacy had been the robust systems and processes which had been introduced into the Trust, without compromising on quality, a restructured Programme Support Office, vacancy panels and

PRMs (performance review meetings). SAd said that the Board were assured that the TD had delivered value to the organisation.

JS noted that the TD had left before the end of the appointed term of one year. CWa (Chris Warricker) asked whether the Trust had a process to review projects against objectives. SAd said that he had been given assurance at the BoD FPC that this would be in place for all future projects. The Committee was not reassured by these explanations and requested further assurance from the NEDs that the Trust had embedded a project review process for all future projects. **ACTION**

The Committee asked that the written report previously requested be provided; AB noted that a summary existed but had not been presented to the meeting and agreed to send this to MLo (Michèle Low) prior to the next CoG. **ACTION**

- FPC annual planner: AB (Amanda Bedford) circulated a copy of the BoD FPC agenda setting planner, which she noted was a living document.

Discussions on items to be reported to the Full Council meeting

Ag. Ref	**Report to Council** Drafted ready for formal presentation in the report
6	**Report from Board of Directors' Finance & Performance Committee** No specific report from the BoD FPC and NED was given by the NED. The Committee had intended to consider the extracts from the IPR and BAF which had been circulated with the papers. However, the discussions and exchanges ensuing on the risks around financial forecasts and CIPs were prolonged and inconclusive, so that the IPR was not addressed. **SRR11 Estates strategy** – PBa (Paul Bartlett) noted that two estates issues had come to his attention recently, i.e. the Trust's involvement in the Ashford Borough Council's Big Spring Clean and the interface between the WHH hospital estates team and local residents. The Committee observed that the strategy would be closely linked to the STP and Clinical strategy. JS noted that the Council had previously been advised that the Trust's strategy was being developed in partnership with KCC. The Committee requested that the planned update on the STP for the next Full Council meeting include information about the Estates Strategy – how it was being managed and links with partners. **ACTION** **BAF SRR5 Failure to achieve financial forecast** – CWa commented that there was a lack of detail in the BAF, for example, CIPs were barely mentioned; there was no action plan and the risk was rated Amber when it should be Red. SAd said that the BAF was a key document to enable NEDs to focus on holding the executive team to account; it highlighted the risks, provided details on

mitigation and listed the action and outcomes. This allowed the NEDs to monitor progress. The Committee commented it was aware of the purpose of the BAF.

While acknowledging that guidance allowed CIPs to be non-recurring, CWa noted that at the Trust had set a target of £20M CIPs cash-releasing, recurring savings. It was not appropriate to make a change to this principle from recurring to one-off in order to meet the target figure at year end.

SAd said performance against savings targets should not be considered in isolation but in the context of the increased pressures on beds and the impact on all areas of the service. Current forecast was for the Trust to achieve £23M savings. The target had been predicated on workload pressures and the Trust re-visited targets regularly and revised them if needed on the basis of the various factors which had impacted on performance. He told the Committee that their role and Council's was to be assured that NEDs were ensuring that the Trust performs as well as it could do given those pressures, rather than pick at detail. Quality of care and patient safety had to be a priority and finance planning had to adapt to this.

PBa commented that the Trust tended to be reactive to outside pressures, for example a flu epidemic, without having the financial planning in place to deal with that contingency. The Trust had one budget only; in other sectors there would be alternative budgets planned to assist in future proofing. SAd noted that private sector businesses could be flexible in other ways, such as reducing the workforce in response to operational demand. He assured the Committee that the Trust's financial planning did take into account the impact of external factors.

SRR1 and 10: Clinical Strategy and STP - JS (John Sewell) noted that SRR1 had effectively been subsumed into SRR10. He believed that they should remain separate as a lot of detail was lost within SRR10. SAd noted that the Clinical Strategy was driving the STP as far as the Trust was concerned; the STP, however, was the process that all NHS organisations were required to follow.

Conclusions:
MLo invited members to add to the framework list after the meeting if they wished. Recurrent items for future meetings would be: delayed discharges of care, financial impact of A&E demand and staffing pressure, including agency costs, overseas visitor charges, and other items arising from these notes. The Committee wanted to focus on the added value that the Council could bring at the strategic level. SAd suggested they should ask for assurance from the NEDs that lessons had been learned around planning for winter pressures, which in reality were cyclical and predictable.

ACTION

The meeting expressed concern that the BAF as presented for this meeting was not fit for purpose, SRR 6 being closed was cited as an example – this had been closed down but it was suggested that it should be re-opened in response to the

	STP process. SAd was asked to take this to NEDs for a reply. **ACTION**
7	**Outcome of NHSI assessment of Trust status** MLo advised the Committee that at her recent quarterly discussion with NHSI, the regulator identified financial performance and A&E management as two key issues so that it was not certain that the Trust would come out of special measures. SAd said a decision was expected 23 February. NHSI were looking for assurance that the Trust had an improvement trajectory which could be sustained. They recognised the challenges presented in having multiple sites as the Trust serves a geographically large area. Agency spend had been identified as a key pressure with a very high vacancy rate for clinical consultants – 17 at present. The Trust had access to an NHSI consultant, Mark Hammond, at no cost, to support the critical financial planning for the coming year. He would be working with the Trust for around six months and attending the BoD FPC on a regular basis. NHSI had also agreed to investment in the Trust's planned Leadership Programme to support the senior and middle management teams to deliver on the change. JS noted that figures within the Single Oversight Framework, had been released against a new national measure on organisational leadership; the Trust was at level 4, the lowest performers. The Committee requested that an update be given at the next Full Council meeting on performance against the oversight framework. Links to the websites providing this data would be helpful. **ACTION** The Committee recognised the impact of being in Special Measures if special measures were not lifted. CWa sought assurance about the process the Trust had followed to ensure that the Trust had addressed the recommendations in the CQC report relating to finance. He suggested if these had been addressed the Trust would not now be at risk of being placed in Financial Special Measures. The Committee agreed that if the Trust was in Financial Special Measures at the time of the next Full Council then this would be reflected in the discussions at the Chairs' Agenda setting meeting the next day.
8	**Charges to overseas patient visitors** MLo noted that this issue had been raised at Board level with the response given that the cost of recovering the monies would not be cost effective. In view of its topicality, the Committee suggested that this should be added to the list of recurring Committee items. **Scrutiny of IPR & Finance information to BoD** Deferred.

Other business

Review of the meeting:
PBa suggested that sticking to a finish time could limit the depth and range of the discussion.

The relevance of the Committee looking at general performance issues in the IPR was questioned because this duplicates the work of other CoG Committees. This question would be addressed in a review of the Committee structure, and in the context of the new Strategic Oversight Framework.

REPORT TO:	**COUNCIL OF GOVERNORS' MEETING**
DATE:	**30 MARCH 2017**
SUBJECT:	**REPORT FROM CHAIR OR THE NOMINATION AND REMUNERATION COMMITTEE**
REPORT FROM:	**PHILIP WELLS, Elected Governor, Canterbury COMMITTEE CHAIR**
PURPOSE:	**Discussion**

BACKGROUND AND EXECUTIVE SUMMARY

The CoG Nomination and Remuneration Committee met on 15 February 2017 and this report provides the Council of Governors with an update on the issues covered and makes recommendation for consideration by the Council.

LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.

RECOMMENDATIONS AND ACTION REQUIRED:

The Council is asked to:

- consider the proposal from the NRC that the outcome of the Governor Effectiveness Survey is discussed at an away day;
- consider the proposal from the NRC that the survey should be revised before it is next used;
- Approve the revised policies on –
  - Chair Appraisal
  - NED Appraisal
- note the process developed for the recruitment to the NED vacancy

Report to Council

NED Recruitment

Junetta Whorwell and Sarah Andrews temporarily joined the Committee to assist with the recruitment of a NED to replace Gill Gibb given that, of the existing Committee members, Jane Burnett had left the Council, Michael Lyons was currently unwell, Carole George was not standing for re-election and Geraint Davies does not attend regularly. Junetta and Sarah were the only two Governors to respond to the general invitation to join the group and would have voting rights.

The Committee considered, and were satisfied with, the level of involvement from the Director of HR in the NED recruitment process.

The draft recruitment pack and process was considered and the following points noted.

- The importance of ensuring that the finer detail was correct if template documents had been used and that the grammar was consistent.
- The time commitment to be adjusted in the advertisement in light of discussions on item 8 in the agenda on NED expectations and priorities. [Outcome – increase to 6 days.]
- The introduction on the Trust to be updated.
- The Trust Chair advised that the following were desirable attributes for applicants for this recruitment:
  - an experienced and motivated NED to join the Board; recent NED appointments were new to the role and Gill Gibb had had a lot of NED experience.
  - a background in working with potential partners, patients or public services users, perhaps through the third sector, to help bring the patients' perspective to the work of the Board.

- Reference to the clinical strategy needed to be revised to 'driving the strategy forward and implementing' rather than 'defining'.
- Applicants to be given the opportunity for an informal conversation with the Trust Chair and the Chair of the CoG NRC.
- Advertisement to be clear that the appointment cannot be held concurrently with an NED appointment with another NHS organisation.
- The draft pack was circulated to members once updated on the basis of the Committee's discussions.
- Applicants would be asked to provide a supporting statement with their application. It was confirmed that Harvey Nash did not encourage applicants to follow a set template for this statement and background checks were completed on the applicants, following the Fit and Proper Persons test.
- There were no unsuccessful applicants from the past two recruitment processes who could be called back.
- Shortlisting would be undertaken by the whole Committee with virtual contributions if needed; all applications were considered at these meetings, there was no pre-screening.
- The link to the application pack would be circulated to members when it went live.

It was agreed that the interview panel would be:

- Philip Wells, as Chair of the CoG NRC
- Nikki Cole, Trust Chair
- Reynagh Westcar-Jarret and Sarah Andrews, Governors
- Barry Wilding, NED

Junetta Whorwell to attend as an observer and Amanda Bedford to support the site tour if any candidates requests one.

After the meeting virtual agreement was sought, and given, from the Committee members for Junetta to take Reynagh's place on the interview panel.

The vacancy closed on 24 March and the shortlisting meeting is on 31 March with interviews on the 18 April. The Full Council will be provided with a summary of the outcome of the interviews and their recommendation. As with the last NED appointment, Council will be asked to respond to virtually in order to avoid any delays in the appointment process.

Chair and NED Appraisal

The Committee received a revision of the Chair Appraisal and the NED Appraisal Policies for discussion to agree the drafting for formal recommendation to the Full Council for agreement.

There was a full and wide ranging discussion on this item and which I believe is of value to report in more detail than normal in a Chair's report. The item below on Non-Executive Expectations and Priorities, is also relevant and reported in detail.

The agreed revision of the Policies are appended at Annex A and B.

Notes of the discussions:
Before leaving the meeting while the Chair appraisal was discussed, the Trust Chair asked the Committee to consider what should be included in a definition of leadership of the Council. Historically this has consisted of forming agenda and facilitating meetings and has not included influencing the way the Council works. NC wondered whether the meeting considered that there should be a wider remit.

The Committee made the following points during the discussion.

- The involvement of Governors in providing feedback to inform the appraisal of the Chair and NEDs was difficult as there was limited opportunity for observing performance. While it was acknowledged that Governors needed to be part of the process, the efficacy of involving Governors in this way was challenged.
- However, how Governors relate to the Chair and the Chair to Council was seen to be a critical element of the appraisal.
- The Senior Independent Director (SID) said he would be canvassing for views from a wide range of people and groups and he expected those to be varied and perhaps divergent.
- The SID noted that an agreed framework was needed to ensure that the Governors' contribution could be made in timely and considered fashion. He confirmed that he was receiving HR support from a senior level.
- The appraisal process needed to be linked to the job description and the objectives agreed in the previous year. For the Chair's post the job description was wide ranging and it was recognised that some priorities needed to be set. There also needed to be clear definitions, as recognised by the Trust Chair's request to Committee to consider the definition of leadership.
- It was recognised that the existing job description for the Chair role was two years old and taken from the candidate pack issued at the time of advertising the post. This was the basis of Nikki Cole's contractual arrangement with the Trust.
- The priorities within the job description and the Chair's objectives needed to be agreed at the start of the year as part of the process to provide the framework for looking at performance. There should be clear outcome measures. Those asked to provide feedback as part of the process needed to be reminded of the objectives, definitions as appropriate and the outcome measures to reduce the impact of differences in interpretation.
- The SID confirmed that he would expect all Governors to be asked to contribute to the Chair's appraisal and agreed that this had to be done within a clear framework. The suggestion in the paper being presented to the Committee that this be done by way of a questionnaire was intended as a way to provide that framework.
- The view was expressed that personal objectives had not been clearly established for the current year and that appraising on the basis of outcomes identified as Trust

objectives was perhaps unfair if the individual concerned did not have the capacity in their role to influence these.

- The SID explained his plan for the current appraisal round: to take the intelligent board as a starting point for what the Chair should be doing, and monitor guidance on the role and map this to the objectives set out at the NRC meeting a year ago, then canvass views of Governors, NEDs, EDs and NHSI. This would provide a table of objectives and a way of assessing whether or not these had been achieved based on a consensus of the views put forward.
- Training for those undertaking Chair or NED appraisal need only be for those who do not already have appropriate experience and then it should be tailored, not standard Trust training.

Leadership:

The Trust Secretary advised the meeting that the Code of Governance provided a definition of leadership. It was suggested that it should be for the Chair to provide their understanding of the definition leadership against which they would be appraised. The view was expressed that not all on the Council may concur with the definition given and an acceptable definition may be different between Council and Board, both of which were led by the Trust Chair. PW said that with respect to the Council leadership could either be making a decision about the direction of travel and leading the Council there or enabling the Council to make those decisions, more of a facilitation role.

There was support for the view that an enabling and support role was preferred, with a recognition that not all Governors may agree.

The Trust Secretary noted that the Code of Conduct and the NHSI guidance were consistent and was reflected, perhaps in a more realistic manner, in the job description within the candidate pack. It was suggested that this was the definition which would need to be applied to the current appraisal round.

It was agreed that the policy for both the Trust Chair and NEDs would be revised on the basis of the discussions at the meeting and circulated for agreement prior to submission to the Full Council meeting on 30 March. Appraisals would not take place until after year end. It was agreed that a definition of leadership would also be drafted for consideration by the Full Council. If there were any suggestions that a changed definition should be applied to the current appraisal, 2016/17, this would need the explicit agreement of the Chair.

It was confirmed that for 2016/17 appraisal would be informed via a short and succinct set of questions posed to Governors via a questionnaire circulated with the job description, code and agreed objectives. The same principle to be applied to NED appraisal with the inclusion of 360 degree review of an agreed, relatively small number of governors.

Governor Effectiveness Survey

The Committee had been asked to consider the responses to questions 1 – 5 and 35 – 41 of the survey. Following discussion it was agreed that more time needed to be given to considering the outcome, and to recommend to the Full Council that it be considered at an away day. An alternate view was expressed that there had not been anything coming from the survey which was unpredictable and it would be better to move forward. Time should definitely be given to revising the survey for future years; the design could be improved and more valuable data collected.

Non-Executive Directors: expectations and priorities

The Trust Chair led a session where members considered the time given in a month by the NED Chair of FPC to provide a measure for the Committee to consider what time commitment should be used for the NED advertisement. The outcome was:

Monthly
I day on Board or Board Development meeting
0.5 reading & prep for the meeting; could be 400 – 600 pages
0.5 for FPC meeting
0.5 for prep for the meeting plus agenda setting
3 x 0.5 attendance at other BoD Committees as a member

Quarterly; some additional time for reading
0.5 for CoG FPC
Site visit
Hospital oversight committee (one of the various meetings that NHSI has mandated for NED membership)
Consultant interviews – GMC required NED involvement
CoG Full Council meeting

The following points were noted during the discussions:

- The time commitment for NEDs exceeds the 3 days currently advertised.
- Increasing the commitment may deter applications from those who are currently working; these are the candidates who will bring up to date skills and working experience to the Board.
- Those who have the capacity to meet the commitment are more likely to be retired.
- The remuneration cannot be changed for this recruitment; the day rate for the post, if advertised at 6 days a month, is unlikely to be attractive.
- Candidates can be told at interview that the remuneration would be reviewed.
- There was concern that making a change for this recruitment would mean that the NEDs had been appointed under different expectations.
- BW noted that the current NEDs were all aware of the reality of the time commitment. NC said that she had made it clear to the appointed candidate at the last two recruitments that the time commitment was in reality greater than advertised.
- Reviewing the CoG Committee structure and the expectations for NED attendance at the same could help to reduce the time commitment.

It was agreed that the time commitment used for the advertisement for the current recruitment be set at 6 days. The Committee would undertake the regular review of NED remuneration at its next meeting and the outcome of these discussions would be taken to the May Full Council meeting. The Committee requested that data on day rates be produced for their next meeting.

Committee membership

As the discussions had suggested that the CoG Committee structure may be reviewed it was agreed to defer detailed discussion on this paper. The paper summarised some of the practical issues relating to management of the Committees.

As an interim measure the Committee agreed to recommend to Council that the new Partnership Governor be asked to take the place of his predecessor. Also, that the same system be followed as with the NRC should circumstances mean that the number of governors fall.

Annex A

DRAFT: MARCH 2017 V1

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

POLICY FOR APPRAISAL OF THE CHAIRMAN

APPROVED BY COUNCIL OF GOVERNORS:

REVIEW DATE:

POLICY STATEMENT

1. Good governance of Foundation Trusts requires that Board Chairs, like all other senior staff, should be subject to a formal scheme of annual performance appraisal. This ensures that Chairs are themselves appraised, and receive regular feedback on their performance, and on their responsiveness to external constituencies. It can provide evidence to NHS Improvement of accountability if needed, and can also support decisions by the Council of Governors on what actions to take when a Chairman's term of office comes to an end (including whether or not to reappoint without a further open competition).

2. This Policy statement sets out the appraisal process for the Chairman of the Trust only. It [has been agreed] by the Council of Governors and reflects EKHUNHS FT Guidance on the Statutory Duties of Governors.

3. Annual appraisal enables:
   a) Review of the performance of the Chairman of the Board
   b) Update of the job specification and personal objectives for the chairman
   c) Identification of personal development needs of the Chairman set out in a personal development plan where necessary

4. A new Chairman on appointment will have an initial appraisal meeting with the Senior Independent Non-Executive Director (SID) within 4 to 8 weeks of appointment. The primary purpose of this meeting will be to:
   a) Confirm that the job description is clear
   b) Agree objectives
   c) Agree a Personal Development Plan

   The key components of the Chairman's appraisal are attached at Appendix 1.

5. An incoming Chairman will have a formal mid-year review, to appraise progress, in October/November. The end of year appraisal will take place in April/May, together with objective setting for the year ahead.

6. In subsequent years, the annual appraisal should take place within 2 months of the financial year end, and should:
   - Review performance and achievement over the preceding year;
   - Review the job description to ensure it remains up to date;
   - Identify changes to the chairman's objectives for the forthcoming year;
   - Agree any requirements for personal development, to be set out in a PDP if necessary.

7. Mid year reviews should take place for established chairs at the request of either the chair or the SID as appraiser.

8. The appraisal process should be conducted by the SID, drawing on the views of and perspectives of other directors, governors, and other stakeholders. The areas covered by the assessment are attached at Appendix 2. The timetable for the appraisal process is attached at Appendix 3.

9. The SID should present the outcome of the appraisal process (including the Chairman's written self-evaluation) each year to the Council of Governors, with a view to reaching agreed conclusions.

Annex A APPENDIX 1

WHAT IS APPRAISAL?

Appraisal is a participative two-way process between the appraisee and the appraiser. When appraisal is being used effectively, it is a positive, supportive and developmental process.

It provides the opportunity for the Chairman of the Board of Directors to reflect on his/her performance as an individual and as part of a team, suggest improvements, as well as providing a vehicle for expressing perceptions and feelings.

KEY COMPONENTS OF THE APPRAISAL SYSTEM FOR THE CHAIRMAN

The Trust considers that the following are some of the key characteristics of a successful appraisal system:

- There is top level support, from all the Trust Board and Council of Governors.

- Training for the SID will be made available if deemed necessary or if the SID requests training in undertaking the appraisal.

- There must be effective mechanisms in place for delivery of the appraisal. These should include allocation of time to undertake appraisals, time for on-going discussion of individual and organisational needs and clear but simple paperwork.

- Objective setting in advance is essential.

- The formal appraisal will consist of a discussion between the SID, who will have sought input from other directors, the governors, other relevant external stakeholders and the Chair who will have completed a self-evaluation of his/her progress against the objectives for the year.

    - The SID will solicit feedback from those concerned by seeking oral assessments against the chairman's personal objectives for the year in question, supplemented if necessary by written assessments;
    - The SID will solicit specific feedback from all governors on the Council on those aspects of the chairman's objectives that are visible to the CoG, normally using a simple questionnaire/rating scale agreed in advance with governors.

      The content of the questionnaire will be agreed at the start of the year when the Chair's objectives are set. These be clearly defined and have measurable outcomes. The objectives and the job description will be appended to the invitation to Governors to complete the questionnaire.

- All those taking part in an appraisal should be aware of what happens to their documentation and ensure that issues of confidentiality are addressed.

- Summaries of job descriptions, personal objectives, and appraisals should be held by appraisers and copies retained by the appraisee.

Annex A APPENDIX 2

AREAS COVERED BY ASSESSMENT

The Chairman's appraisal will be led by the Senior Independent Director, facilitating input from the Chief Executive, Board of Directors and members of the Council of Governors.

The appraisal will cover the following assessment:

- Performance against individual objectives;
- Effective chairmanship of the Board of Directors and Council of Governors;
- Effective leadership of both the Board of Directors and Council of Governors;
- Effective challenge at Board and committee meetings;
- Attendance at Board, committee meetings and Council of Governor meetings;
- Corporate understanding and strategic awareness;
- Commitment;
- Holding to account;
- Personal style;
- Independence and objectivity;
- Self-development and attendance at required training (including mandatory training) and development sessions and events.

Annex B

DRAFT MARCH 2017 V1

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
NON EXECUTIVE PERFORMANCE EVALUATION PROCESS

1 Introduction

NHS Improvement's Foundation Trust Code of Governance states that the Board of Directors should undertake a formal and rigorous annual evaluation of its own performance and of its committees and individual directors.

This document sets out the process for the evaluation of NED performance. It reflects EKHUFT Guidance on the Statutory Duties of Governors.

2 The process

2.1 The Chairman will lead the process for evaluation of Non-Executive Director performance, facilitating input from the Chief Executive, Board of Directors and members of the Council of Governors.

2.2 The Chairman will meet with each non-executive director to set their objectives within 3-6 months of their start date. Thereafter the non-executive director will be appraised annually on the anniversary of their appointment against the objectives. The objectives for all non-executive directors will fall into three areas:

- The Trust annual objectives (set March / April each year)
- A specific improvement that they will lead in their chairing role; and
- An objective linked to the use of their expertise in a specific piece of work for the Trust.

2.3 The evaluation will consist of the following.

- 360 review with the NED nominating reviewers from:
    - the Council of Governors – total of five;
    - the Chief Executive;
    - Executive Directors; and
    - other relevant senior staff.

- A discussion between the Chair and Non Executive Director relating to performance against their specific objectives, professional and personal development. This will be structured using the form at Appendix 1.
- A table showing the NED's contributions to consultant recruitment panels, ward and staff visits, attendance at Council of Governor meetings and Committees, and completion of mandatory training.
- Agreement of objectives for the coming year.

2.4 The questions that will form the 360 degree element and thereafter provide the discussion between the Chair and non-executive director are:

- What does the NED do well and what is good about it?
- What could the NED improve and what would this result in?
- How has the NED performed as the Chair of a Board Committee
- How has the NED performed as a member of the Board

NOTE: for Governors answering the 360 review questionnaire, there will be a tick box to give them the option 'I have not attended a Board meeting' for this question.

- On a scale (1 to 7) is this NED a team player?
  A freeform box for additional comments will allow the appraiser to add anything they think relevant.

2.4 The outcome of each appraisal, in the form of a summary report by the Chairman, will be discussed at the Council of Governor's Nomination and Remuneration Committee and reported to the next private Council of Governor meeting. These outcomes will form the basis of any decision to re-appoint the non-executive director.

Revised:

Annex B Appendix 1

Non-Executive Director Reflections

Please summarise the key points of the appraisal emphasising any key areas for development.

1. Contribution to meetings.

2. Understanding of governance and role of the Board.

3. Understanding of the NHS environment.

4. Understanding and awareness of EKHUFT Strategic Objectives.

5. Interaction with members of staff, Governors and other Board members.

6. Commitment and attendance.

7. Independence and objectivity

8. Self development.

9. Behaviours: the prompts below combine the Trust's agreed behaviour statements with the Nolan principles, bracketed.

Compassionate - we treat others with kindness and respect **Calm** – we stay calm approachable and professional **Collaborative** *(Openness)* - Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands. **Honest** *(Honesty, Integrity, Objectivity)* - Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest. Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties. In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit. **Accountable** *(Accountability)* - Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office. **Inspiring** *(Selflessness & Leadership)* - Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends. Holders of public office should promote and support these principles by leadership and example

10. Impact

11. Previous year's objectives:
Please set out your key achievements against your personal objectives for the previous year

12. Objectives for the coming year

13. Personal development objectives

14. Any additional comments

REPORT TO:	**COUNCIL OF GOVERNORS' MEETING**
DATE:	**30 MARCH 2017**
SUBJECT:	**REPORT FROM THE CoG QUALITY COMMITTEE**
REPORT FROM:	**SARAH ANDREWS COMMITTEE, CHAIR**
PURPOSE:	**Discussion**

BACKGROUND AND EXECUTIVE SUMMARY

The CoG Quality Committee met on 8 February.

This report provides the Council of Governors with an update on the issues covered and makes recommendation for consideration by the Council

LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.

RECOMMENDATIONS AND ACTION REQUIRED:

The Council is asked to:

- **AGREE** the proposed Governor Indicator for the Quality Accounts; aand
- **NOTE** the discussions on charging blue badge holders for parking.

Report to Council

This meeting took place after Gill Gibb's resignation and the BoD meeting that morning had been chaired by Barry Wilding whose commitment did not allow for him to attend the CoG meeting.

Helen Goodwin, Deputy Director of Risk Governance & Patient Safety, attended to provide feedback from the meeting.

14 Governor indicator: the Committee was advised that it would be of value to the Trust to audit the time taken to first consultant review. This was part of the single oversight framework; a consultant review should happen within 14 hours of a patient being admitted on an emergency pathway. The Trust had to report on this so comparable data was available and an audit via the Governor indicator would add rigor to the reporting. The audit criteria were clear and data should be available from records to provide a robust outcome.

The Committee considered other possible indicators: HG confirmed that clear progress was being made with VTE; the End of Life communication pathway was currently being embedded so this would be a good indicator to consider for next year; and Sepsis

indicators were well monitored and visible within existing systems.

The Committee noted that the Full Council had agreed with the Committees recommendation at the last meeting that the indicator should be suggested by the Director of Nursing. The Committee unanimously **SUPPORTED** the proposal for the indicator, and agreed to propose this to the Full Council by way of this report.

Parking proposal – blue badge holders

The Committee received a paper on parking charges for Blue Badge holders which had been approved by the Trust's management Board. It would be taken to the next public Board meeting and the Chief Executive had asked for this Committee to comment on the content to help inform the Board's discussions. The following points were noted in the discussions:

- Clarification was provided regarding whether staff permit holders who also have a blue-badge are affected, and in particular those who have the 'volunteer' version of the staff permit e.g. governors. It was noted that volunteers with staff permits would have access to the disabled bays allocated for staff use.
- Concerns were raised over the disabled parking capacity at WHH and it was explained that a further 24 designated blue-badge bays have recently been created in zone 9 at the rear of Richard Stevens ward to deal with the demand at peak times.
- A question was asked around how disabled bays within the pay-on-foot (POF) car parks would be affected. It was explained that there are no designated disabled bays within the POF car parks and therefore there would be no concessions for blue-badge holders who choose to use those car parks. It was acknowledged however, that some of the old disabled bay markings have bled through and are now visible which might cause some confusion for users, but that this will be rectified by the Trust as soon as possible.
- The Committee supported the introduction of a charge for blue-badge parking, applying the principle that all users should contribute to the running of the car parks. It was also agreed that a £2 daily charge, and the other concessions available such as the fortnightly ticket, are fair especially in comparison to other hospitals.
- The location of Pay & Display machines was discussed and assurances provided that the machines would be no more than 50ms away from the furthest blue badge parking bay. The view was expressed that blue badges were provided to those who were unable to walk more than 50 steps and suggested that this should be taken into account when siting P&D machines.
- There was agreement that the signage recently put up in pay station shelters, following a suggestion by a Governor, to inform users that <u>all</u> surplus income from the Trust run car parks is reinvested into the Trust was useful and should help with the concerns that some people have around the car parks being run by a private firm.
- The proposed approach of advance open and transparent engagement with patients, visitors, staff and other stakeholders was agreed as the best way to notify users of the changes, but it was hoped that some discretion would be provided on the part of the parking attendants in terms of ticketing vehicles where no payment had been made in the period shortly after the change takes effect. Assurances were given that we would continue to adopt a fair and consistent view on both ticketing of vehicles and dealing with any subsequent appeals.

Report from Board of Directors' Quality Committee

The Committee received a report from Helen on the issues discussed at the BoD Quality Committee that morning which included:

- security risks;
- consideration of the IPR;
- patient safety Board terms of reference, which were designed to make Divisions more accountable;
- the annual report into Learning Disability was approved;
- an update on the mortality review being required from organisations following the Southern Health incident;
- infection prevention and control update;
- quality strategy targets – performance update;
- quality strategy 2017/18 objectives;
- patent aspects of the BAF – the Chair felt there was adequate assurance around these;
- the corporate risk register – some risk scores have been increased in response to the increased activity levels, which will be taken; and
- Integrated Complaints, Claims and Incidents reports presentation including lessons learned and the time staff are having to spend in Coroner's Court. HG said she was looking at whether this was a local or national issue.

The following points were noted in the discussion:

- A brief update was provide on the changes in the local Coroner's courts following national guidance and the range of outcomes available to the Coroner. The Trust has a good in-house legal services team who have developed skills to ensure staff are supported during the inquest process and able to manage cases in a cost effective way.
- Sepsis - Helen gave an update on the Trust's performance in relation to giving antibiotics within one hour of arrival. The recent reduction in performance was linked to the increase in emergency activity and identifying in-patients whose condition was deteriorating. She explained the action the Trust was taking to address this, including the work on increasing community beds to facilitate patient discharge.
- Quality measures, performance – Helen noted that stretch targets had been set deliberately to help drive improvement. Some would not be met, including category 2 pressures sores and she advised that a category 4 case had been reported to STEISS the previous week; the only one in year. Targets for the coming year would be focussed on pathway improvements rather than reducing incidences.
- The Committee noted that it was disappointed that some targets had not been achieved. Helen commented that the increased activity in the Trust had impacted on a number of the targets; there was, however, a basic level of care which must be provided to all patients.
- Helen noted that the Trust was performing at a better than peer level including number of new harms report via the safety thermometer and standardised mortality ratio.
- A patient concern issue about disabled access to toilets by the fracture clinic in WHH was raised by a governor. It was agreed that this would be added to the Members concerns database
- Quality Strategy objectives: Helen confirmed that the strategy would bring together the third year of the strategy with a look at forward planning for the coming 18 months and explained how community care planning would need to link into this. Helen commented that the number of key performance indicators chosen needed to be

limited to a manageable level and focussed on the needs of the Trust's patients, otherwise it becomes meaningless and it was impossible for staff to identify the priorities.

- The Committee discussed the information available to support the meeting, noting that the minutes of the BoD Quality meeting were included in the public Board papers.

REPORT TO:	**COUNCIL OF GOVERNORS' MEETING**
DATE:	**30 MARCH 2017**
SUBJECT:	**REPORT FROM THE CoG WORKFORCE COMMITTEE**
REPORT FROM:	**SARAH ANDREWS COMMITTEE, VICE-CHAIR**
PURPOSE:	**Discussion**

BACKGROUND AND EXECUTIVE SUMMARY The CoG Workforce Committee met on 30 January 2017. This report provides the Council of Governors with an update on the issues covered and makes recommendation for consideration by the Council	
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
RECOMMENDATIONS AND ACTION REQUIRED: The Council is asked to note and discuss the report.	

Report to Council

As Alan Holmes was unable to attend the meeting, it was chaired by Sarah Andrews.

Time to recruit: It was noted that the post-offer checking stage of the process seemed to be an area where delays occurred. The Director of HR advised that the Trust was looking at joining with other local NHS organisations to see if some joint working could cut down on time taken. In addition there was work underway to streamline internal processes.

People Strategy and Key Performance Indicators (KPIs) data

The Director of HR spoke to the presentation provided in the meeting papers noting that an implementation plan had been tabled at the BoD SWF meeting. She concluded the presentation saying that the People Strategy was the road map for HR and the Bo SWF holds them to account via regular reports and KPIs.

In discussion the following points were noted:

- High Staff turnaround: the HR Director advised that the report into turnaround did not indicate a specific problem area or pattern. The Retention manager had done a lot of work with business partners around improving induction, objectives setting and appraisal and this did seem to be impacting as first year leavers were reducing, albeit the high level figures had not yet reversed.
- Staff Survey: it was confirmed that completion rate was increasing; the last figure was 48% which was higher than the national average.
- Robustness of planning: The Director of HR agreed to a point made by a Governor that there were a number of factors which were outside of the Trust's control, including the STP and clinical education. The plans were a robust as possible.

- KPIs: it was noted that. The Director of HR agreed with and observation that the vacancy rate and overtime rate seemed to be linked. She was looking into the data to understand what factors were causing the changes to overtime rate.
- Training: a Governor commented on the impact on staff morale and development from cutting training budgets. SIB said that she would look into this further.

Feedback from Board of Directors' Strategic Workforce Committee

Colin Tomson provided feedback from the meeting that morning:

- KPIs – the Committee looked at these in detail
- Staff Survey – engagement with the survey was good; 75 of the indices went up; responses to leadership and development questions had improved. CT noted that this was from a low base and the Trust was now showing as average against the 40 organisations managed by Picker surveys – the full national picture would be available the following month. Divisional teams will then be looking at the survey.
- Medical engagement survey – again there were better results overall and an action plan was in place. One challenging area was non-consultant doctors who felt that they were not as involved with the Trust.
- Medical Education – HEKSS had reported improvement with the junior doctor training situation although there remained concern about rotas for senior staff, so the Trust was still exposed in this area. Relative to other Trusts the EKHUFT position was stable, others were decreasing.
- Ward establishment review, six month report – CT said that the Committee felt there was risk in this area as the Trust was struggling to meet recent changes which had increased establishment. The Trust was looking at both re-modelling jobs and looking at different sourcing.
- Apprenticeships – an interesting programme with both a potential to 'grow' staff for the organisation and a possible risk as the organisation had to pay up front for the apprentice and re-claim from the apprenticeship levy later.

In discussion the following points were noted:

- Colin was asked whether the NEDs were assured that the plans included sufficient focus on marketing and pro-active encouragement to attract students to the courses which would deliver qualified staff to meet demand in the future. He said that this had been looked at briefly in the BoD SWF and he would take back the comments to that meeting.
- It was noted that the demographics of the Kent area would be changing quickly and was concerned at the impact of the removal of bursaries. Debra Teasdale noted that the Universities were working in conjunction with partners to address this and had an active outreach team with a number of bursaries available. The Universities have done a lot of work to provide funding for extra costs such as uniforms and DBS checks. Attracting students to Kent would be key to success in managing the complex task of balancing course places with NHS Trust requirements and having sufficient applicants to fill those places. Colin Tomson agreed that promoting Kent, and using all available networks to do so, was critical. He concurred with a comment from a governor that it was important to use creative ways to do so – to make the jobs attractive and interesting and ensuring the wide range of opportunities are made clear. Research had shown that engaging at primary school level was the most effective.
- It was noted that MECC had confirmed that charitable funds could not be used to proide scholarships.
- Colin Tomson was asked to comment on media coverage had covered two health related stories: the safety implications of remodelling nursing care in response to the recruitment pool of qualified staff being insufficient; and the capabilities and

competency of nurses recruited from overseas. Assurance was sought about the scrutiny that the NEDs had applied to these issues.

Colin Tomson advised that a paper had been presented to the meeting that morning on recruitment from overseas which provided confirmation that the Trust required successful applicants to be able demonstrate clinical competency to deliver a safe standard of care – they had to 're-badge', and also to have an acceptable standard in speaking English. The next meeting would receive a presentation from the team leading on the re-modelling work, which included cross organisation collaboration to share staff and create posts which may be more attractive and deliver better care and effective use of technology.

He commented that to support such a level of change it would be essential to communicate effectively with the public to demonstrate the benefits of the change and challenge the status quo.

- KPI data: Colin Tomson noted that sickness levels had increased to that reported – 4.2%. The Director of HR had explained that morning that stress and anxiety was a high contributory factor to this increase and it was not evident that best use was being made of the support available from occupational health. The BoD Committee had established that there were areas in the Trust where sickness was falling despite the external pressures and these were where routine management processes were in place - such as regular meetings, setting objectives and appraisals - and applied. A governor commented that where staff were working under pressure the risk of errors increased.

  Colin Tomson confirmed that information provided from exit interviews was taken into account when planning. One trend which had been identified was nursing staff choosing to take early retirement.
- It was noted by a governor that throughout the reports presented to Board, including workforce, there was a lot of mention of action plans. Were the NEDs assured that these were being implemented properly and in a timely fashion. Colin Tomson said that his committee had invited the Divisional lead teams to attend and present their action plans so he had confidence that NEDs were able to challenge directly and have evidence of the progress or otherwise. The Executive team monitored the divisional teams on a more regular basis which again gives confidence.

  Colin Tomson said that linking the action plans and feeding concerns from that work into the risk registers and BAF would be a way to improve the visibility. The BAF provided information about risk, mitigation and progress. He was asked whether the NEDs were assured that this action was delivering what the Board wanted to see. He said that he had partial assurance about this from the BAF, he would hesitate to confirm he was fully assured across the whole programme.

  Colin Tomson confirmed that there were heat maps to highlight possible cause and effect correlations. He was also assured that there was action taken to address these, however he did not believe that it was possible to eliminate all risk.

  A governor queried whether NEDs were assured that the organisation had a hold on the total impact when changes were made citing vacancy freezes on administrative staff which might be detrimental on a practical basis as it meant that clinical staff were not sufficiently supported to deliver their role. Colin Tomson accepted the point, although he noted that the pressures had to be addressed and he was not sure there was an alternative. However, the effectiveness of a vacancy panel needed to be reviewed

regularly and the risk recognised that a necessary vacancy may not be passed.

Feedback from other Committees

It was noted that the MECC was now receiving a regular report on the Membership Concerns Database. CG reported that it had been discussed at the last meeting of the MECC; AB had reported that now the database had been developed it should be easier to process the concerns in a more timely fashion. DT noted that it was useful to record positive experiences also.

DT reported that the University was working on monitoring unconscious bias across organisations and providing training for recruiters. JWh reported back to the Committee on the recent Trust's BME conference. A particular problem had been for staff to have time to attend the conference.

Any other business

Before leaving Colin Tomson challenged the meeting to consider whether the Council's meeting structure was working. The following points were noted:

- the meeting had been productive with the members able to challenge the NED and receive assurance.
- the relationship with the NEDs had improved.
- it was suggested that more time was needed to embed the system before making changes.
- it was early to make changes; there were positives in the new system although there were concerns that the number of Council meetings had reduced so there was less opportunity for Governors to meet as a whole group.

REPORT TO:	**COUNCIL OF GOVERNORS' MEETING**
DATE:	**30 March 2017**
SUBJECT:	**REPORT FROM THE CoG AUDIT AND GOVERNANCE COMMITTEE**
REPORT FROM:	**CHRIS WARRICKER COMMITTEE, CHAIR**
PURPOSE:	**Discussion**

BACKGROUND AND EXECUTIVE SUMMARY

The CoG Audit and Governance Committee met on 27 January 2017.

This report provides the Council of Governors with an update on the issues covered and makes recommendation for consideration by the Council

LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.

RECOMMENDATIONS AND ACTION REQUIRED:

The Council is asked to note and discuss the contents of the report.

Report to Council

Grant Thornton and the Well Led Governance Review

BW (Barry Wilding) was asked to comment on the appointment of Grant Thornton (GT) to undertake the Well Led Review given that Monitor guidance states this should be done by an independent body who has not been involved in any governance review for the Trust in the last three years; GT had undertaken finance governance review in that period.

BW explained the process and confirmed that, at the time, NHS I were asked whether GT would be eligible in light of the finance review and this was confirmed. The procurement process followed using an agreed list of criteria against which applicants were scored and GT were appointed. It was noted that the previous review undertaken was in a different area from the Well Led review.

The committee asked the NEDs to explain to the Council their involvement in the procurement process for the Well Led Framework Governance Review, and in particular explain how they failed to ensure that only independent reviewers were asked to quote on such a fundamental piece of governance work when Monitor guidance clearly states reviewers must be independent.

With respect to holding the Board to account, BW explained that once a quarter at the Board Integrated Audit and Governance Committee (IAGC) reviewed progress on the actions taken to implement the 24 recommendations made in the report. BW reported that 21 were either completed or on track with the remaining 3 red rated. These were:

- R6 Board responsibility for safeguarding - there appeared to be some confusion in

the organisation about the lead responsibility between the Director of Nursing, who has the statutory responsibility, and the Director of Operations, who was perceived as having operational responsibility. An awareness campaign was underway to make this clear within the organisation. The Committee noted that this issue had also been raised within the CQC report in that the Chief Nurse could not herself hold responsibility for Child Safeguarding and that this needed to be a named individual.

- R14 Having a recognised approach to Quality Improvement supported by training – the Trust had plans for a Leadership Development Programme which had stalled waiting for NHS I to agree to the cost investment. This had now been received and work was being progressed.
- R17 Clinical Audit – this remained an area of concern and an issue which the Board of Directors Quality Committee were focussed on. Key to reaching a resolution was to clearly identify, and closely manage, those clinical audits which were national requirements from the local divisional audits. BW confirmed that this was on the Board Assurance Framework and was being looked at by the Internal Audit

BW clarified the position with respect to R16 – re-establishing site management in the Trust. It was not intended to re-introduce site management; it was considered that the concerns highlighted as part of this recommendation were being addressed via other actions. BW commented that there was now a better understanding of, and a greater use made of, the Board Assurance Framework and Risk Register process to bring key problems to light. Issues relating to cross site working difficulties were evident within the registers and he was now seeing a change in culture towards actively seeking resolution for problems. This provided him with the assurance that the concerns underlying R16 were being addressed appropriately.

BW advised the Committee that the scrutiny of the action against the recommendations by the IAGC would continue. The NEDs on the IAGC cross referencing the information provided about progress against the information they received via other sources, both in reports and during site visits and meetings. He confirmed that the IAGC were giving sufficient attention to the review recommendations. It was recognised that a Well Led review had to be undertaken every three years; there was currently no plan to repeat the review at an earlier stage.

The Committee was disappointed to note that the most recent version of the action plan had not been provided to the meeting.

Feedback from Board of Directors Integrated Audit and Governance Review

BW provided the meeting with a summary of the key issues discussed at the BoD IAGC meeting that morning:

- Board Assurance Framework: this was reviewed by the Committee quarterly to gain assurance that action was being taken to progress the issues and to challenge where it was felt that this was not evidenced or not moving fast enough. BW commented that the process was improving although there was more progress to be made.
- Annual priorities quarter three review: BW reported that there were some data issues which meant that there was not a clear picture around some of the priorities. The Committee had been promised that data presentation for the Quarter 4 report would be improved.
- STP governance arrangements: BW commented that this was a huge area and £4.2M had already been used to set up the governance arrangements nationally. BW said that the Committee had been happy with the documentation describing the arrangements. The view had been taken that there needed to be investment in the leaders who would be delivering the changes to inspire and equip them;

Colin Tomson would be taking this forward via the BoD workforce Committee. The Committee also raised issues around funding and ensuring that there is common understanding between the organisations. The IAGC had asked the Chief Executive to report to the next meeting on progress with the agreement of the current draft Memorandum of Understanding and approval of the governance documentation. BW noted that there was no formal update on the issue of a potential of a Unitary Authority for East Kent Councils.

The Committee discussed the implications of the STP process and the Trust's position. BW clarified that SRR1: risk to the clinical strategy, will be consolidated with SRR10: STP risks, and the background information will travel into the revised risk. He confirmed that having the risk relating to the STP process recognised the concerns about the process, the challenges to be faced in reaching an outcome and the need for mitigation. The BoD Committee were clear that it was important that background detail was included to provide assurance and evidence that the issues had been thought through.

Attention was drawn to the number of red areas on the BAF, in particular relating to Appraisal (SRR8). BW explained to the Committee that the role of the BoD IAGC was to ensure that the risk process was working correctly. As such the red ratings provided some assurance that the process was working to flag areas of concern. It would be for the relevant BoD Committee to focus on the detail of the risk and hold the executive to account for delivery of improvements.

It was noted that in the entry for SRR 5 Failure to achieve financial plan, one line was repeated four times; BW explained that this was because the risk was present in all four divisions. The Committee noted that there had been improvement in the action sections with more detail provided. BW commented that the IAGC were still applying pressure to ensure that regular updates were provided.

The aim was to achieve a mature risk system where there was consistency in application and it was fully embedded across all levels of the organisation. BW noted that it was important to understand that the priority when managing risk was not financial – patient safety was paramount.

BW reported that other items covered by the IAGC included:

- Fraud report
- Deep dive on corporate risk 1
- Minor changes to the corporate risk handbook
- Single tender waivers
- Annual accounts timescale
- 2016 Audit plan – BW noted that materiality had been reduced from £10M to £6M. Interim audit review starts next month.
- Two internal audit reports had been received. For one - temporary staffing – only partial assurance had been given mainly due to use of off frame agencies. This had been addressed by the introduction of new policies in October. This will be reviewed. BW noted that performance on follow-up actions had significantly improved and was now in access of 90%.

Barry Wilding left the meeting at this point.

Effectiveness Survey:

The Committee considered the questions in the survey relating to Governance issues. The following points were made:

- It was felt that an overarching analysis would be useful as the responses were open to individual interpretation, which on occasion was quite different. The survey needed a full discussion by the Full Council.
- The Committee were disappointed by the relatively low proportion of governors who responded – around 66%, although it was recognised that this would be seen as a good response rate generally.
- It would be interesting to find out why governors failed to complete the survey.
- The error in question 24 was noted in that the role of the Governors was not to hold the Board to account but to hold the NEDs to account. There was a similar misrepresentation in question 27 relating to the Lead Governor in that there was no leadership element to the role. PW noted that when the survey was drafted he had asked that there was consistency with the previous survey, hence the inclusion of the lead governor question.
- The answers to question 41 provided an interesting insight into Governors' perception of their role.
- The Committee discussed the usefulness of the effectiveness survey and recognised the difficulty of Governors being able to judge the impact of the Council's work. It was suggested that this should be identified to the Governors by the Trust, in particular the Trust Chair who chairs both the Board and the Council.
- It was recognised that the Council did not have the remit to influence operational issues be taken, it could challenge NEDs to provide evidence for assurances given about operational performance. The view was expressed that the Council was becoming more effective in challenging the NEDs, recognising that this needed to be done within the bounds of respect.
- JW commented that the ability of Governors to bring to the relevant Trust committee concerns expressed to them by members was one way in which governors were demonstrating their effectiveness.

Governor Training

The Committee formed the view that the most valuable training was that provided by trust staff on their areas of expertise and training from organisations linked to the Trust, such as the external auditors. They requested that urgent action be taken to follow through on the offer from Philip Johnson, KMPG, to provide some be-spoke training for governors. Training to provide skills for specific governor roles, such as recruitment, would be valuable.

Travelling to London for the NHSP training was not seen as the most valuable use of governor time. The ability to ask questions about the local situation was of greater value than more generic training. Providing the NHSP training on site in Canterbury was seen as valuable – the core skills training was deemed to be excellent and the effective questioning course could also be of value.