East Kent Hospitals University NHS Foundation Trust

COUNCIL OF GOVERNORS PUBLIC MEETING
FRIDAY 3 AUGUST 2018, 10.10 am
BOARDROOM, KCH

AGENDA

HOUSEKEEPING				
1.	**Chair's introductions**	To note	10.10 (05")	*Stephen Smith Trust Chair*
2.	**Apologies for Absence and Declarations of Interest**	To note		*Stephen Smith Trust Chair*
3.	**Minutes from the last Council of Governors' Public meeting held on 10 April 2018**	To agree Appended		*Stephen Smith Trust Chair*
4.	**Matters arising**	To agree Appended		*Stephen Smith Trust Chair*
BUSINESS				
5.	**Trust Chair report**	To discuss CoG 11/18	10.15 (10")	*Stephen Smith Trust Chair*
6.	**Board of Directors Finance and Performance Committee report**	To discuss CoG 12/18	10.25 (20")	*Nigel Mansley NED member FPC*
7.	**Board of Directors Quality Committee report**	To discuss CoG 13/18	10.45 (20")	*Barry Wilding NED Chair*
8.	**Board of Directors Strategic Workforce Committee report**	To discuss CoG 14/18	11.05 (20")	*Jane Ollis, NED, member SWC*
9.	**Board of Directors Integrated Audit and Governance Committee report**	To discuss CoG 15/18	11.25 (20")	*Barry Wilding NED Chair*
BREAK (10")				
10.	**Verbal report from the Trust CEO**	To discuss	11.55 (15")	*Susan Acott CEO*
11.	**Council of Governors Membership Engagement and Communication**	To discuss	12.10 (15")	*Philip Bull MECC Chair*

	Committee report	CoG 16/18 To follow		
12.	**Task and Finish Group – Constitution Review and Governor Role Document review**	To agree CoG 17/18	12.25 (10")	*Alison Fox* *Trust Secretary*
13.	**Annual Council and Council Committee Effectiveness Review**	To agree CoG 18/18	12.35 (05")	*Alison Fox* *Trust Secretary*
14.	**Update on Appointment of External Auditors**	To agree CoG 19/18	12.40 (05")	*Alison Fox* *Trust Secretary*
	CLOSE			
15.	**ANY OTHER BUSINESS** Please notify Committee Secretary of matters to be raised – deadline 48 hours before the meeting.		12.45 (05")	*Stephen Smith* *Trust Chair*
16.	**QUESTIONS FROM THE PUBLIC**		12.50 (05")	*Stephen Smith* *Trust Chair*
17.	**DATE OF NEXT PUBLIC MEETING** See below		12.55 (05") Ends: 13.00	*Stephen Smith* *Trust Chair*
18.	**MEETING RULES REVIEW**			*Stephen Smith* *Trust Chair*

Future meeting dates

Date	Type	Time	Location
2018			
6 November	Closed Public	9.30 To follow	WHH Boardroom
10 September	Annual Members Meeting	17.30	Spitfire Ground, Canterbury
2019			
14 February	Closed Public meeting Joint with Non-Executives	9.30 To follow 14.00	Margate area Venue TBC

MEETING RULES

Procedural

- Turn mobiles off/to silent
- One conversation at a time – no side conversations
- Listen to others – let them finish before commenting
- Things said remain confidential

Behavioural

- State views and ask questions
- Share all relevant information
- Focus on interests, not positions
- Test assumptions and inferences
- Discuss un-discussable issues

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS MEETING (PUBLIC) PRESENTED ON 3 AUGUST 2018

ACTION POINTS FROM THE COUNCIL OF GOVERNORS MEETING (PUBLIC) HELD ON 10 APRIL 2018

MINUTE NUMBER	DATE OF MEETING	ACTION DESCRIPTION	LEAD	DUE BY	PROGRESS
OUTSTANDING ACTIONS FROM PREVIOUS MEETINGS					
21 SEPTEMBER 2017					
31/17	21.09.17	**Matters arising:** share Nigel Mansley's review of Finance Board papers with Governors.	AB		Update 11 January 2018: draft circulated to Chair and Chief Executive. Update 10 April 2018: the report would be fed into board discussions on governance once completed. **Update 3 August 2018: at meeting**
05/18	15.01.18	**Matters arising** Contact Glenn Douglas about the process in place for Governors to be involved in the STP process	Peter Carter	Immediate	Update 10 April 2018: verbal at meeting **Update 3 August 2018: at meeting**
08/18	15.01.18	**Chair's report** Matrix for joint visits to be issued by the end of the month.	AB	End of month	Update 10 April 2018: action delayed. **Update 3 August 2018: joint visit programme now underway.** **Propose: close action**
19/18a	15.02.18 Joint meeting	**Governance issues** Conflicts of interest - provide illustrative flow charts showing how potential scenarios could be managed.	AF	Next meeting	Update 10 April 2018: in development. **Update 3 August 2018: to be included in work on developing the Governor Responsibilities pack.** **Propose action closed.**
19/18b	15.02.18 Joint meeting	**Governance issues** include reference to criminal offences in the guidance, including fraud, and add a table giving examples of breaches in each category.	AF	Immediate	Update 10 April 2018: guidance updated to include table, to be re-issued to cover criminal offenses. **Update 3 August 2018: to be included in work on developing the Governor Responsibilities pack.** **Propose action closed.**

MINUTE NUMBER	DATE OF MEETING	ACTION DESCRIPTION	LEAD	DUE BY	PROGRESS
19/18c	15.02.18 Joint meeting	**Governance issues** Speak with the new Trust Chair to highlight the need to make the work of the NEDs more visible to governors	CTo	As appropriate	Update 10 April 2018: verbal update at meeting **Update 3 August 2018: suggest that these two items were covered with the discussions at the last meeting when the Chair sought Council views on how the Board and Council could work more effectively together.** **Propose actions closed.**
19/18d	15.02.18 Joint meeting	**Governance issues** Council to consider how to make their work in holding NEDs to account more visible.	All	As appropriate	
ACTIONS FROM THE LAST MEETING HELD ON 10 APRIL 2018					
23/18	10.04.18	**CEO Report Staff survey presentation** Consider presenting on results to Council.	AB	As appropriate	**Update 3 August 2018: to be included in agenda scheduling.** **Propose close**
28/18	10.04.18	**AOB - GDPR** Check whether GDPR prevents the Trust from contacting existing members for confirmation that they wish to remain on the database.	AB	As appropriate	**Update 3 August 2018: contact permissible.** **Propose close**

UNCONFIRMED MINUTES OF THE COUNCIL OF GOVERNORS PUBLIC MEETING 10 APRIL 2018, 10.30HRS BOARDROOM, KENT AND CANTERBURY HOSPITAL, CT1 3NG

PRESENT:

Stephen Smith	Trust Chair (Chairman)	StS
Sarah Andrews	Elected Governor – Dover	SAn
Julie Barker	Elected Governor – Rest of England and Wales	JBa
John Bridle	Elected Governor – Ashford	JBr
Mandy Carliell	Elected Governor – Staff	MCa
Jenny Cole	Elected Governor – Swale	JCo
Paul Curd	Elected Governor – Dover	PCu
Roy Dexter	Elected Governor – Thanet	RDe
Sharon Hatfield-Tugwell	Elected Governor – Staff	SHT
Alex Lister	Elected Governor – Canterbury	ALi
Ken Rogers	Elected Governor – Swale	KRo
John Sewell	Elected Governor – Shepway	JSe
Marcela Warburton	Elected Governor – Thanet	MWa
Chris Wells	Partnership Governor – Council	CWe
Nick Wells	Partnership Governor – Volunteers	NWe
Philip Wells	Elected Governor – Canterbury	PWe
Junetta Whorwell	Elected Governor – Ashford	JWh

IN ATTENDANCE:

Phil Cave	Director of Finance and Performance	PC
Alison Fox	Trust Secretary	AF
Amanda Bedford	Committee Secretary (minutes)	AB

MIN.NO		ACTION
17/18	**CHAIR'S INTRODUCTION** The Chair opened the public session of the meeting.	
18/18	**APOLOGIES FOR ABSENCE AND DECLARATION OF INTEREST** Apologies for absence were received from Philip Bull, David Bogard and Debra Teasdale. The revised Register of Interests was noted.	
19/18	**MINUTES OF PREVIOUS MEETING** The minutes of the meeting held on 11 January 2018 were agreed as an accurate record. The minutes of the meeting held on 15 February were agreed as an accurate record.	
20/18	**MATTERS ARISING** **31/17 Matters arising – Nigel Mansley's review on finance reporting** AF updated the meeting that the final report on finance from	

	Nigel Mansley would be provided to the chief executive and chair. This report would feed into board discussions on governance. **03/18 Indemnity funds** PC provided an update on the indemnity issue that no further funds were available. Action to be closed. **05/18 Governor involvement in the STP** The Chair would be meeting with Glenn Douglas on 19 April and would feed back to the Council. **12/18 Comments on Committee framework** The Chair indicated that a consideration of changes in governance had begun and the points would be included. Close action. Closure of other items was agreed in accordance with the 'propose action closed' designation.	
21/18	**TO RECORD THE APPOINTMENT OF:** **a) Trust Chair** The appointment was noted. **b) Trust Chief Executive Officer** The appointment was noted. **c) Lead Governor** The appointment was noted.	
22/18	**VERBAL REPORT FROM THE TRUST CHAIR** The Chair related that finance had been a main issue at the public board. The Trust had an aim to move into the top 20% of the country for performance. The strategic development plan around this would be based on four clinical targets: four hour waits in A&E, response to treatment, cancer waits, and stranded patients. All these parameters needed a system approach and the Trust values around 'We care' would underpin the work. The Trust's CQC score for caring was outstanding. The Chair commented that there were issues to address around governance. A Trust in Financial Special Measures needed to be meeting more frequently than every couple of months. A business consultancy report had been received from consultants, Grant Thornton. The Chair observed that larger organisations functioned with fewer boards and committees than the Trust. Difficulties arose when there was a lack of clarity over which groups or committees were official and therefore held true responsibility, and if too many papers were produced.	

	For a close working relationship between the Council and the Board, accountability on both sides should be clear. There needed to be consideration of how non-executive directors could feed back to the Council more directly. It was suggested that the Trust had gone too far in reducing the amount of time non-executives spent at meetings. A sustainable middle ground should be the aim. The low frequency of board meetings was highlighted, a situation that meant that non-executives were often challenged about things that were no longer an issue. SAn commented that duplication should be avoided. Meetings should dovetail with Board meetings so governors can be immediately appraised of situations. AF noted that previously this had been facilitated. However, small groups of governors did not have delegated authority so the whole Council needed to be involved. Administrative capacity could be a concern. The Chair commented that Trusts around the country had different approaches. In some, the non-executive chair met with the governors on a quarterly basis. ALi observed that it is difficult to appraise a person if they are the only source of information. The staff survey had revealed concerns around communication. ALi asked if there was a way to broaden access to information. The Chair gave the examples of visits to wards and public meetings, but there could be other ways to increase governor engagement. It was noted that at one point a governor being present at Board committees been considered, although there had been resistance. It was suggested that this could be cost and time effective. AF commented that a majority of other organisations did not have governors sitting on Board committees. This was for reasons of confidentiality and ensuring that the duties of the non-executives and governors remained separate. A number of Trusts identified key committees for governors to attend, for example those around quality and safety. KRo said he had experience in another Trust where governors attended committees as observers, not members, and this had been successful. PC said he had had a similar experience. NWe noted that, if governors were excluded from attending Board committees, governor committees then built up to duplicate functions. It was suggested that governors could have an ‘active observer’ status. It was noted that governors observing non-executives on patient	

	safety visits had been helpful in the past. JWh highlighted that governors are elected by the public and must remain aware of this in communications with non-executives. It was stated that many governors felt opportunities to make a difference were limited. AF observed that governors should be supported to enable effective communication with constituents. It was noted that transparency was important and highlighted that constituents could be members of staff. The Chair noted that this was an area which was sure to be considered again at a future date.	
23/18	**VERBAL REPORT FROM THE TRUST CEO** As Susan Acott had been unable to attend the meeting, PC provided an update. He commented that the executive was very focused on the four targets previously discussed. Susan Acott had mentioned the medical school in her report to the Board. The Kent and Medway Stroke services consultation was out. Further work with CCGs was ongoing on the East Kent hospitals services leads configuration. The staff survey had been a key focus for the organisation. The response rate had increased to 50% but results were not good. AF noted that the annual priorities for the Board were included in the public Board papers. Feedback from staff, received while doing voluntary work in QEQM, had focused on the departure of Matthew Kershaw and the difficulties over the winter. A question was asked as to whether governors would receive a presentation on the staff survey results. AF said that this would be taken into account as part of the agenda setting for the Council meetings. **ACTION: consider a presentations on the staff survey results.** It was suggested that staff felt reasons for change were not always adequately communicated. MCa disagreed with the view that there was a lack of communication. It was suggested that the issue was not a lack of communication but how things were communicated. JBa commented that patient care was central to the values of the organisation, and staff who delivered that care should be valued. A question was asked as to when the annual priorities would become fixed. AF replied that there had been small tweaks after the April meeting. The finalised priorities would be available by the end of the month.	AB

	JWh had recently carried out peer review visits to the William Harvey. Staff seemed content and were aware of what was happening within their unit. There were opportunities for other governors to do peer review visits.	
24/18	**COUNCIL OF GOVERNORS NOMINATIONS AND REMUNERATION COMMITTEE REPORT** PWe noted that interviews for a new non-executive director were being held the next day. There had been a divergence from policy in the recruitment process. Policy was to use a scoresheet to shortlist applications, but this was not possible as 43 applications had been received. The policy would be changed to indicate that a record should be kept of how candidates were assessed for shortlisting. AF noted that the decision on appointing the non-executive was a Council decision. KRo asked when the last skills audit of the non-executives had taken place. The Chair replied it had been done at a Board meeting four weeks ago. The Council **NOTED** the report.	
25/18	**ANNUAL COUNCIL AND COUNCIL COMMITTEE EFFECTIVENESS REVIEW** AF noted that the survey had been kept the same as previous years to enable benchmarking. A new section could be added to include specific questions on governance. This was **AGREED**.	
26/18	**COUNCIL OF GOVERNORS COMMITTEE MEMBERSHIP – ANNUAL REVIEW** AF indicated that committee membership had been based on skills and preferences, but was open for discussion. SAn clarified that, although there were members of committees and elected chairs, all governors could attend any committee. Only members could vote, but AF noted that there was not much delegation to the committees. It was observed that the shortlisting meeting during NED recruitment was not open to non-members of the Committee. MCa queried the frequency of committee meetings. AF replied that the audit committee was ad hoc, NRC was typically quarterly or as needed and MEC was quarterly. The committee membership was **APPROVED**.	
27/18	**TRUST ANNUAL REPORTING AND SELF-CERTIFICATION**	

	PROCESS AND TIMEFRAME AF gave a presentation on NHS Foundation Trusts, Self-Certification 2018 – what, why and how. Copy appended to papers. AF noted that risks were identified and then mitigated. The Trust could then positively self-certify. Governance covered systems and processes, board governance and governance lower down in the organisation. Annual effectiveness surveys were carried out for each committee. There had been some minor changes in terms of how information was provided and how quickly actions were closed. The skills audit ensured the Board had the necessary range of skills. The Trust had a number of undertakings from NHSI relating to the governance condition, dating back to 2014. AF had been attempting to get some of these lifted but had not yet been successful. The Board were able to self-certify that the Trust was meeting those conditions. A document of provider licence conditions was available, including all the evidence that the conditions were met. Each was allocated to a committee that then provides assurance to the Board. The audit committee would consider the process before making a recommendation to the Board on what kind of declaration should be given. Comments from the head of internal audit and KPMG would also feed into this. An internal audit had found the process to be very robust. Assurance that governors had been given adequate training was not a licence condition but was a provision of the Act. Development sessions, the induction process and NHS provider events attended would be considered by the Council in May and comments fed back into the Board. A list of commissioner requested services was available if needed. It was anticipated that the Trust would be able to confirm and self-certify this condition. The information was no longer uploaded to the NHSI portal but it could be spot audited. Responding to a question about whether external training was relevant to governor training, AF stated that it was not. The Council **NOTED** the presenation.	
28/18	**ANY OTHER URGENT OR IMPORTANT ITEMS** AB noted that that the General Data Protection Regulation (GDPR) was coming into effect on 25 May. For the membership database, the legal basis was that the data was required for the	

	Trust to meet its statutory responsibilities. Work was ongoing with the information governance lead. The public membership database provider was no longer used to hold a staff database, and instead the Trust electronic staff record was used. GDPR provided an opportunity to refresh public membership data. There were around 7,500 people on the public membership database who might not be aware that they were on the database or want to be on it. Those people could be contacted and asked if they were interested in remaining members. This could be discussed further at the next membership engagement and communication committee. ALi queried whether Trust were permitted to contact people in this way under GDPR. This point was discussed and would need to be clarified. NWe queried if there was still guidance around what percentage of the population served should be a member. AB replied that there was not. KRo commented that, instead of memberships of individual NHS organisations at East Kent, there should be a move to one joint membership. JWh asked if governors' data, for example addresses, was available to members. AB confirmed that it was not.	AB
29/18	**QUESTIONS FROM MEMBERS OF THE PUBLIC** No questions were raised.	
30/18	**DATES OF NEXT PUBLIC MEETING** 21 June 2018, morning, QEQM	
31/18	**MEETING RULES REVIEW** AF commented that sessions around the 'We care' values had identified appropriate behaviour for meetings and been agreed by governors. In a number of environments meeting rules were reviewed after every meeting to ensure all attendees were happy the rules had been followed. There were no further comments. The Chair closed the meeting.	

REPORT TO:	**COUNCIL OF GOVERNORS' MEETING**
DATE:	**3 AUGUST 2018**
SUBJECT:	**TRUST CHAIR'S REPORT**
REPORT FROM:	**TRUST CHAIR** **STEPHEN SMITH**
PURPOSE:	**DISCUSSION**

BACKGROUND AND EXECUTIVE SUMMARY

This report provides an update to the Council on key issues.

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:

To note the content of the report for discussion at the meeting.

2gether Support Solutions

The first phase of the 2gether Support Solutions project is due to go live on 1 August 2018 when the services currently provided by Serco transfer to the new company. I will provide a briefing on the launch at this meeting. The second phase of the project is due to go live in October, when further support services will transfer.

A total of nine governors were able to attend the briefing meeting given by Keith Palmer on 24 July, which included a presentation from Finbar Murray, the company's Managing Director. Liz Shutler was also present to help answer any questions raised. Some of the issues covered were:

- Provision of healthy food options
- Governance arrangements
- Impact on staff, including pay and conditions
- Potential implications for the League of Friends shops.

This is an exciting project for the Trust and care has been taken to include the Trust and Serco staff involved in the developments. The name has been chosen as it reflects the ethos the company wishes to operate within: using effective and innovative solutions to deliver services while meeting the company's social responsibilities and engaging with the community.

Non-Executive Director changes

The Council will be aware that Colin Tomson will be leaving the role of NED at the end of August. An open recruitment exercise was conducted earlier this year to find his replacement and Sean Reynolds will be joining the Board from 20 August following his retirement as an Air Marshall in the Royal Air Force.

Sunny Adeusi will come to the end of his first term of office as a NED on 31 October this year. In the closed Council session, Philip Wells, Chair of the CoG Nominations and Remuneration Committee will present their recommendation to Council for how this vacancy

should be managed.

I will be considering Board Committee membership once the Council have taken its decision on managing Sunny's end of term of office. One decision which I will be discussing with Council is the appointment of a Deputy Trust Chair on Colin's departure.

Joint Site Visits

A number of the Joint Site visits by small teams of one Executive, one NED and two Governors have now taken place. The feedback has been very positive and a lot of work is being done to fully establish a rolling programme for the visits which will see every team in the trust visited. A more detailed report is provided at Annex A, for your information.

Each visit has resulted in the identification of several actions to be taken and these are being taken forward. I will forward to you a report on these before the meeting; it has not been included with this report as two of the visits are recent, so the actions are currently being worked on and I wished to give you as full a report as possible.

I intend to provide regular update reports on the visits to both Council and Board via my Chair's reports.

Annex A

Joint Site Visits

BACKGROUND

The programme plan is for two hour visits by a team of one Executive Director, one Non-Executive Director and two Governors with an itinerary which includes a mix of clinical, non-clinical and corporate areas. Seven to eight visits are scheduled in two month cycles, based on the Executive Directors' diaries, trying to ensure that attendance by each of the NEDs and Governors is evenly spread in each cycle. The aim is for every team in the Trust to be visited by a joint team.

The programme began with a visit to the Royal Victoria Hospital on 18 May and one to Buckland Hospital on 21 May. Due to the size of the hospitals it was possible to cover the whole site with one visit. A further four visits have now taken place; two at QEQM, one to KCH and one at WHH.

The Board and Council will receive reports on the visits via the Trust Chair's report.

FIRST REPORT

The programme began with a visit to the Royal Victoria Hospital on 18 May and one to Buckland Hospital on 21 May. Due to the size of the hospitals it was possible to cover the whole site with one visit. A further four visits have now taken place; two at QEQM, one to KCH and one at WHH.

A report is made after each visit; as the programme moves forward, the structure for the reports is being refined. The visits are intended to be informal, so the report template is succinct, aiming to capture the key observations in each area and any actions identified; with any that are of an urgent nature highlighted for immediate attention. The Corporate support team use an action table to ensure that these are carried through to completion.

Scheduling for the next three cycles, from August to December has begun. Once these are in place planning will be done on a one cycle rolling programme to ensure that the dates and times for the visit are in diaries well in advance.

INITIAL FEEDBACK ON THE PROCESS

This has been an evolving process with feedback from early visits used to improve the process moving forward.

The feedback from team members has been positive and that the visits are of value, specifically:

- Staff have welcomed the opportunity to show case their areas and talk with Board members and governors.
- The visits have highlighted areas where action can be taken to make life better for staff and also areas where immediate action was required to address a particular concern. The visits have, therefore, had a tangible outcome.
- NEDs and Governors have found it helpful to see first-hand the work being undertaken in the Trust, particularly in the more 'hidden' areas and by the back room teams.

One area which continues to be a challenge for arranging the visits is communication about available dates – some Board and Governors respond to requests for availability faster than others and some have very limited availability. This does make it difficult to ensure that the workload for the visits is spread evenly. Some NEDs and Governors have undertaken a number of visits and this needs to be balanced going forward so that all NEDs and governors participate equally.

Obtaining a definitive list of all clinical, non-clinical and corporate teams/areas and creating visit programmes with a mix of all three which take a logical route within the hospital has been a major, and ongoing, challenge. It is expected that it will take between 6 and 10 months to cover every area in the Trust on the basis of 7 to 8 visits in a two month period. However, once this is achieved it will be simple to take forward as a rolling programme.

Other key lessons have been:

- Timing of the visits
  - This needs to be tailored to the work load in the areas being visited; visits during busy periods need to be avoided.
  - Best to avoid the end of the day and Friday afternoons.
  - Need to take into account impact of external factors, such as school holidays.
  - Some out of normal hours visits may need to be scheduled; both to ensure that staff working at these times are involved in the programme and to assist NEDs and Governors who have daytime commitments to participate equally.
- The teams need a named member of staff to contact in each area on the itinerary.
- Named individuals need to be briefed as to the purpose of the visit and asked to provide a short explanation of the work being undertaken in the area.
- Some of the areas visited are small, so the team needs to be kept to a maximum of four and the visit curtailed if it is clear that it is creating difficulty for the staff.
- Team members need to keep in mind that this is a listening exercise.

It is anticipated that as more visits take place, and advanced preparations become the norm, these early challenges will be overcome and the process will be less resource intensive.

REPORT TO:	**COUNCIL OF GOVERNORS' MEETING**
DATE:	**3 AUGUST 2018**
SUBJECT:	**Report from the Chair of the Board of Directors' Finance and Performance Committee**
REPORT FROM:	**Chair, Board of Directors' Finance and Performance Committee** **Sunny Adeusi**
PURPOSE:	**DISCUSSION**

BACKGROUND AND EXECUTIVE SUMMARY

This report provides Council with a summary of the work of the Board of Directors' Finance and Performance Committee (FPC). It is the first report since the Council agreed the new agenda structure whereby the Chair of each Board of Directors' Committee will report formally to Council twice a year. The report highlights how the NEDs on this Committee hold the Board to account for Finance and Performance

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 discuss this report and take the opportunity to share with the Non-Executive Directors present intelligence arising from Governors' engagement with FT members and the public relevant to the work of the Committee as reported to the Trust Board.

Background

The Board of Directors' Finance and Performance Committee (FPC) usually meets in the last week of each month. The Committee terms of reference are attached at Annex A.

The membership is as follows:

Members:
Sunny Adeusi, NED (Chair)
Nigel Mansley, NED
Keith Palmer, NED
Philip Cave, Director of Finance & Performance
Lee Martin, Interim Chief Operating Officer

Attendees:
Paul Stevens, Medical Director
Sally Smith, Chief Nurse & Director of Quality
David Baines, Deputy Finance Director
Liz Shutler, Director of Strategic Development and Capital Planning (for specific items)

The meeting is open to all members of the Board of Directors.

The Committee last met on 3 July 2018 and a report of this meeting will go to the Board of Directors meeting scheduled for 10 August 2018. The report will be issued on 3 August and

will be published on the Trust's website. The last report from the Committee to the Board went to the 8 June 2018 meeting and can be accessed on the Trust website at:

https://www.ekhuft.nhs.uk/patients-and-visitors/about-us/boards-and-committees/the-board-of-directors/2018-board-of-directors-meetings/

Chair's report to Council

The purpose of the Committee is to maintain a detailed overview of the Trust's assets and resources in relation to the achievement of financial targets and business objectives and the financial stability of the Trust. This includes:-

- Overseeing the development and maintenance of the Trust's Financial Recovery Plan (FRP), delivery of any financial undertakings to NHS Improvement (NHSI) in place, and medium and long term financial strategy.
- Reviewing and monitoring financial plans and their link to operational performance overseeing financial risk evaluation, measurement and management.
- Scrutiny and approval of business cases and the 2018/19 capital plan.
- Maintaining oversight of the finance function, key financial policies and other financial issues that may arise.

The Committee also has a role in monitoring the performance and activity of the Trust.

To deliver against this remit the Committee has the following items on all agendas.

- Divisional presentation – one per meeting on a rolling programme:
  - Clinical Support Services;
  - Urgent care and Long Term Conditions;
  - Specialist Services; and
  - Surgical Services.
- Integrated Finance and Performance report.
- Cost Improvement programme update
- Finance report.
- Update on the Emergency Department (ED) recovery programme. Going forward the Committee will also be receiving monthly reports relating to Referral to Treatment (RTT) and Cancer standards.
- Financial Special Measures update.
- Financial Risks review.

There are other items which are taken on a quarterly, bi-annual or annual basis; many of these relate to corporate governance requirements, such as annual reviews of the Standard Financial Instructions, Committee terms of reference and the Committee's effectiveness. The Committee also receives ad hoc items, often relating to decisions to be taken around capital planning or business plans.

Given that the Trust is in Financial Special Measures, the Committee's role is particularly significant at this time. Looking critically at operational performance against the current Cost Improvement Plans (CIPs) is an important part of our work and the presentations from the Divisions give members the opportunity to hear from the Senior Team directly to gain assurance, or challenge where appropriate. The Committee expects reports presented to meetings to be data driven, providing an evidence base for any assertions given within the report. Failure to provide data, or inconsistencies within that date, will be challenged.

My report to the Board meeting on 8 June summarised the Committee business during the May and June meetings. At the Board meeting itself there was an update on the expectations from NHS I: to deliver on Quarter I (April to June) income and expenditure run rates; produce a three-year operational plan showing improvement in run rates, and to

improve on constitutional standards. I was able to report that the FPC had received a detailed and robust plan around ED recovery and that similar improvement plans for RTT and Cancer standards were being developed for presentation to the FPC July meeting.

At the June Board meeting the FPC also sought, and received, approval of the 2018/19 capital plan noting that £9m of the capital plan was allocated to the standing items around maintenance, replacement equipment and IT with the remaining allocations relating to high-cost equipment replacement and £2m still to be allocated through a prioritisation exercise.

Finally, I offer my apologies that I am unable to attend this meeting of Council and my thanks to Nigel Mansley for doing so in my stead to take any questions you may have. I have noted that the next report from the FPC to Council is due on 14 February 2019.

East Kent Hospitals University NHS Foundation Trust

TERMS OF REFERENCE
FINANCE AND PERFORMANCE COMMITTEE

1 CONSTITUTION

1.1 The Board of Directors has established a committee of the Board known as the Finance and Performance Committee. It is a Non-Executive committee and has no executive powers, other than those specifically delegated in these Terms of Reference. These Terms of Reference can only be amended with the approval with of the Board of Directors.

2 PURPOSE

2.1 The purpose of the Committee is to maintain an overview of the Trust's assets and resources in relation to the achievement of financial targets and business objectives and the financial stability of the Trust. As well as maintaining an overview of the Trust's operational performance and activity. This will include:-

- Overseeing the development and maintenance of the Trust's financial and performance plans and medium and long term financial strategy
- Overseeing the development of specific financial plans as may from time to time be required by NHSI including financial recovery plans, and other financial undertakings
- To consider the impact of Kent and Medway STP plans on the Trust
- reviewing and monitoring financial plans and their link to operational performance
- ensuring that there is good triangulation between financial, performance, quality and safety and workforce plans
- overseeing financial risk evaluation, measurement and management
- scrutiny and approval of business cases and oversight of the capital programme
- maintaining oversight of the finance function, key financial policies and other financial issues that may arise
- maintaining oversight of the Trust's performance against the contract activity plan;
- maintaining oversight of the Trust's performance against the national standard and recovery trajectories

2.2 As a committee of the Board of Directors, it will:

- Make recommendations to the Board.
- Develop policy.
- Monitor and hold to account.

2.3 The Committee is authorised to investigate any activity within the terms of reference and to seek any information it requires from any employee and all employees are directed to co-operate with any request which in the opinion of the Chair of the Committee is properly made by the Committee.

3 OBJECTIVES

3.1 Financial Strategy

3.1.1 To consider the Financial Strategy, ensuring that the financial objectives are consistent with the strategic direction and quality priorities.

3.1.2 To review long term financial models and strategies including the impact of the Kent and Medway STP.

3.1.3 To review annual operational plans including efficiency targets and savings projects.

3.1.4 To review key medium term planning assumptions.

3.1.5 To review NHSI/LAT /CCG/NHS England, etc publications around financial and operating environment and their link to planning assumptions and models.

3.2 Monitoring Performance

3.2.1 Monitor the achievement of the financial strategy, and financial targets, associated activity targets and how these relate to the performance of the trust in non-financial domains such as patient safety and effectiveness.

3.2.2 Monitor balanced scorecard, and activity and financial performance.

3.2.3 Monitor cost improvement and savings targets.

3.2.4 To scrutinise financial and non-financial performance, trends, projections and underlying data on a monthly basis so that assurance can be sought around any action plans that address emerging patterns in finance or activity.

To oversee the development of financial and non-financial performance reporting, to include:

3.2.5 Greater emphasis on interpretation of the financial position and development of corrective plans where necessary.

3.2.6 Structuring monitoring reports around the key performance statements.

3.2.7 Developing high level metrics to focus the Committee on areas where corrective action may need to be developed

3.2.8 Linking the narrative to implications of compliance with the FT licence, in particular the financial risk rating and other licence conditions

3.2.9 Monitoring agreed actions

3.2.10 To consider the annual reference costs and review profitability analyses.

3.2.11 To review the annual accounts prior to IAGC and Board approval (see section 12)

3.3 Financial Risk Management

To review financial risk and advise the IAGC and Board accordingly:

3.3.1 Review and evaluate key financial risks e.g. tariff changes, contract penalty considerations, CCG/SCG Commissioning intentions, achievement of savings, control of recruitment (and hence pay bill), costs and benefits of underlying additional activity.

3.3.2 Development of risk management process around the evaluated risks linking to Board Assurance Framework providing assurance around active financial risk management [Note: the formal link between the finance risk register and Corporate Risk Register will be through the Risk Management and Governance Group).

3.4 Business Case consideration and Capital Programme management

3.4.1 To perform a preliminary review of proposed major investments.

3.4.2 To establish the overall controls which govern business case investments, using NHSI's guidance on Capital regime, investment and property business case approval guidance for NHS Trusts and Foundation Trusts, and to approve the Trust's Business Case Procedure. In accordance with the Business Case Procedure (ref FPP/B1) and Scheme of Delegation rigorously review and approve business cases. (see section 5.2 below)

3.4.3 To ensure that robust processes are followed, evaluating, scrutinising and monitoring investments so that benefits realisation can be confirmed.

3.4.4 To ensure testing of all relevant options for larger business cases prior to detailed workup

3.4.5 To focus on financial metrics within cases e.g. payback periods, rate of return etc.

3.4.6 To oversee the development and management of the rolling capital programme including scrutiny of the prioritisation process, forecasting and remedial action, and report to the Board accordingly.

3.5 Commercial Income

3.5.1 Ensure new income generating opportunities from non-clinical activities are identified, appropriately vetted and safely implemented;

3.5.2 Ensure mechanisms are in place to provide assurance that all income generating projects are implemented timely and safely;

3.5.3 Review current income streams from all non-clinically related activities;

3.5.4 Ensure a database of all contracts and service agreements are in place and updated regularly;

3.5.5 Benchmark the Trust's commercial income against other NHS providers;

3.5.6 Receives assurance that all potential opportunities are entered on the Aspyre CIPS management system;

3.5.7 Ensure that robust processes are followed, to evaluate, scrutinise and monitor implementation of income generating opportunities so that benefits realisation can be confirmed;

3.5.8 Commission internally supported market opportunity reviews.

3.6 Other Matters

3.6.1 To provide an opportunity for examination of fitness for purpose of the finance function compared to the scale of the financial challenge

3.6.2 To consider ad hoc financial issues that arise (e.g. Private Patient Cap, estate revaluation etc.)

3.6.3 To develop the Trust's Treasury and cash management policies in line with NHSI guidance on Managing Operating Cash. To scrutinise arrangements for a working capital facility and other long terms loans if required, and investment of surplus cash.

3.6.4 To periodically consider changes required to Trust Standing Financial Instructions due to structural change within the Trust, developments in the NHSI regime and the wider statutory/regulatory framework.

3.6.5 To oversee arrangements for outsourced financial functions and shared financial services.

3.6.6 To consider such other matters and take such other decisions of a generally financial nature as the Board shall delegate to it.

4. MEMBERSHIP AND ATTENDANCE

Members

4.1 The membership of the Committee shall consist of at least three Non-Executive Directors, together with the Chief Operating Officer and Finance Director. The committee meetings shall be open to all the members of the Board of Directors.

Chair

4.2 The Chair of the committee will be the Trust chairman or non-executive director as determined by the Nominations Committee of the Board.

Attendees

4.3 The Chief Nurse/Director of Quality, Medical Director, Director of Strategic Development and Capital Planning and Deputy Finance Director may attend.

Quorum

4.4 Business will only be conducted if the meeting is quorate. The Committee will be quorate with at least two Non-Executive Directors and One Executive Director present. If the Trust Chair is in attendance, this will count towards the quorum.

4.5 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Board of Directors meeting as an urgent item.

Attendance by Members

4.6 The Chair and Lead Executive, or their nominated deputy, of the Committee will be expected to attend 100% of the meetings. Other Committee members will be required to attend a minimum of 80% of all meetings and be allowed to send a Deputy to one meeting per annum.

Attendance by Officers

4.7 The Committee will be open to the Chair, Chief Executive and Trust Secretary to attend.

4.8 Other staff may be co-opted to attend meetings as considered appropriate by the Committee on an ad hoc basis

Voting

4.9 When a vote is requested, the question shall be determined by a majority of the votes of the members present for the item. In the event of an equality of votes, the person presiding shall have a second or casting vote.

5. FREQUENCY

5.1 Meetings of the Committee shall generally be held monthly. At the discretion of the Chair, other meetings may be held to fulfil its main functions.

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

6.2 Reference should be made as appropriate, to the Standing Orders and Standing Financial Instructions of the Trust.

6.3 The committee may set up permanent groups or time limited working groups to deal with specific issues. Precise terms of reference for these shall be determined by the committee. However, Board Committees are not entitled to further delegate their powers to other bodies, unless expressly authorised by the Trust Board (Standing Order 5.5 refers).

6.4 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary or advantageous to its work.

7 SERVICING ARRANGEMENTS

7.1 A member of the Board Secretariat shall attend meetings and take minutes.

7.2 Agendas and papers shall be distributed in accordance with deadlines agreed with the Committee Chair.

7.3 Members will be encouraged to comment via correspondence between meetings as appropriate.

7.4 The Committee will maintain a rolling annual work plan that will inform its agendas and seek to ensure that all duties are covered over the annual cycle. The planning of the meetings is the responsibility of the Chair.

8 ACCOUNTABILITY AND REPORTING

8.1 The Committee is accountable to the Board of Directors.

8.2 Chair reports will be provided to the Board of Directors to include: committee activity by exception; decisions made under its own delegated authority; any recommendations for decision; and any issues of significant concern.

8.3 Approved minutes will be circulated to the Board of Directors. Requests for copies of the minutes by a member of public or member of staff outside of the Committee membership will be considered in line with the Freedom of Information Act 2000.

9 RELATIONSHIPS WITH OTHER COMMITTEES

9.1 The Committee will receive reports for scrutiny from the following meetings:

- Private Practice Committee
- Strategic Investment Group
- Management Board (Finance / operational matters)
- Procurement Strategy Board
- Single Oversight Meeting
- Financial Improvement Committee

9.2 The Committee has reliance on/links to Standing Financial Instructions

- Management Board

10 MONITORING EFFECTIVENESS AND REVIEW

10.1 The Committee will provide an annual report outlining the activities it has undertaken throughout the year.

10.2 A survey will be undertaken by the members on an annual basis to ensure that the terms of reference are being met and where they are not either; consideration and agreement to change the terms of reference is made or an action plan is put in place to ensure the terms of reference are met.

10.3 The terms of reference will be reviewed and approved by the Board of Directors on an annual basis.

12. JOINT COMMITTEES

12.1 The Committee shall meet annually in May, jointly with the Integrated Audit and Governance Committee (IAGC) for the purpose of reviewing the annual report and accounts, and annual plan, prior to formal approval by the Board of Directors.

12.2 Meetings shall be chaired jointly unless otherwise agreed by the Chairs of both committees.

12.3 All members of the FPC and IAGC shall be members of the Joint Committee. Attendance by others will be by invitation but will normally include the Deputy Finance Director and Deputy Director of Risk and Governance.

12.4 A quorum shall comprise Chairs of both IAGC and FPC, the Director of Finance and Performance Management and the Chief Nurse/Director of Quality and Operations.

12.5 In all other regards the Joint Committee will operate and be administered in the same manner as set out in each Committee's individual Terms of Reference.

Approved by the Board of Directors: April 2018

REPORT TO:	**COUNCIL OF GOVERNORS' MEETING**
DATE:	**3 AUGUST 2018**
SUBJECT:	**Report from the Chair of the Board of Directors' Quality Committee**
REPORT FROM:	**Chair, Board of Directors' Quality Committee** **Barry Wilding**
PURPOSE:	**DISCUSSION**

BACKGROUND AND EXECUTIVE SUMMARY

This report provides Council with a summary of the work of the Board of Directors' Quality Committee (QC). It is the first report since the Council agreed the new agenda structure whereby the Chair of each Board of Directors' Committee will report formally to Council twice a year. The report highlights how the NEDs on this Committee hold the Board to account for the quality of the services delivered.

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 discuss this report and take the opportunity to share with the Non-Executive Directors present intelligence arising from Governors' engagement with FT members and the public relevant to the work of the Committee as reported to the Trust Board.

Background

The Board of Directors' QC usually meets in the last week of each month. The Committee terms of reference are attached at Annex A.

The membership is as follows:

Members:
Barry Wilding, NED (Interim Chair)
Wendy Cookson, NED
Jane Ollis, NED
Sally Smith, Chief Nurse & Director of Quality
Lee Martin, Interim Chief Operating Officer
Paul Stevens, Medical Director

Attendees:
Jane Christmas, Deputy Chief Nurse
Helen Goodwin, Deputy Director of Risk, Governance and Patient Safety
Director of Infection Prevention and Control
Michelle Webb, Associate Director of Patient Safety
Philip Cave, Director of Finance and Performance
Divisional Medical Directors

Meetings are open to all members of the Board of Directors.

The Committee last met on 4 July 2018 and a report of this meeting will go to the Board of Directors meeting scheduled for 10 August 2018. The report will be issued on 3 August and will be published on the Trust's website. The last report from the Committee to the Board went to the 8 June 2018 meeting and can be accessed via the link below:

https://www.ekhuft.nhs.uk/patients-and-visitors/about-us/boards-and-committees/the-board-of-directors/2018-board-of-directors-meetings/

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Chair's report to Council

The Committee is responsible for providing he Board with assurance on all aspects of quality, including strategy, delivery, governance, clinical risk management, clinical audit and the regulatory standards relevant to quality and safety.

To deliver against this remit the Committee has the following items on all agendas.

- Updates from Committees which report into QC as part of the Trust's governance structure:
    - Patient Experience Group
    - Clinical Quality and Patient Safety Group
    - NICE Clinical Effectiveness Committee
    - Infection Prevention and Control
    - Patient Safety Board
- Emergency Department (ED) recovery plan
- CQC update report
- Quality risks
- Reports from Divisional Governance Boards
    - Clinical Support Services;
    - Urgent care and Long Term Conditions;
    - Specialist Services; and
    - Surgical Services

There are other items which are taken on a quarterly, bi-annual or annual basis including:

Presentation of formal Annual Reports on

- Safeguarding Children and Safeguarding Vulnerable adults – with a mid-year update;
- Infection Prevention and Control report – with quarterly updates;
- Annual Audit plan – with mid-year review;
- Organ Donation – with two update reports in year;
- Research and Innovation annual report;
- Human Tissue Authority (HTA) – compliance with regulations;

Annual

- Setting annual objectives for the Quality Strategy;
- Agreeing the Trust's Quality Account document;
- VTE briefing
- Falls report
- Assessment of the Committee's effectiveness
- Review of the terms of reference

Quarterly

- Integrated Claims, Incidents and Complaints report;
- Report on the Ophthalmology waiting list;
- Quality Strategy Report;
- Reports on the Board Assurance Framework;

Ad hoc

- Reports on in-patient surveys when published;

To help make the agenda more manageable the items are assigned under the following headings;

- Quality Improvement
- Performance and Quality Monitoring
- Quality Governance/Assurance
- Clinical Audit
- Corporate governance

You will appreciate from the summary above, the agenda schedule for the QC is heavy and complex. The Trust Secretary will be working with the Medical Director and Director of Nursing and Quality to review the plan to reduce the repetition within the papers which is currently happening and to improve the flow across the year.

My report to the Board meeting on 8 June summarised the Committee business during the May and June meetings. At the Board meeting itself I noted that the Quality Committee had received an update on how ED performance would be improved and the assurance given that the improvement plan was both robust and realistic. The principal quality risks on the Risk Register had been reviewed and the Committee had noted improvements in the reporting of progress against the risks. There were process control limits on the quality metrics data, which enabled the Committee to review these more objectively. I also advised that the Committee had reviewed and approved the revised Quality Strategy 2018-2021, and recommended this to the Board for approval.

I also highlighted a number of positive areas which the Committee had noted: the friends and family test inpatient satisfaction rate of 97%; the overall patient experience rated green at 91.6%; that the Trust had entered its third month without a never event; substantive improvement in the pressure ulcer rate, which was an indicator of good quality care; and the reducing falls rate.

I look forward to taking the Council's questions on this report on 3 August.

NHS
East Kent
Hospitals University
NHS Foundation Trust

QUALITY COMMITTEE

TERMS OF REFERENCE

1 CONSTITUTION

1.1 The Board of Directors has established a committee of the Board known as the Quality Committee. It is a Non-Executive committee and has no executive powers, other than those specifically delegated in these Terms of Reference. These Terms of Reference can only be amended with the approval of the Board of Directors.

2 PURPOSE

2.1. The Committee is responsible for providing the Board with assurance on all aspects of quality, including strategy, delivery, governance, clinical risk management, , clinical audit; and the regulatory standards relevant to quality and safety.

3. OBJECTIVES

Strategy and Performance

3.1. Oversee the development and implementation of the Quality Strategy with a clear focus on improvement, drawing on and benchmarking against ideas and best practice from external organisations.

3.2. Ensure that the Trust's Quality Strategy and performance are consistent with the goals of the NHS Outcomes Framework.

3.3. Review trends in patient safety, experience and outcomes (effectiveness) using various means including a review of the quarterly Claims, Incidents and Complaints report to provide assurance to the Board on performance and undertake 'deep dives' as appropriate.

3.4. Oversee the development and implementation of action plans arising from both in-patient and other care related surveys with recommendations to the Board as appropriate.

Governance

3.8 Monitor the progress against actions to mitigate the quality risks on the corporate risk register and provide assurance to the Board that adequate steps are taken to reduce the risks in line with the Board's risk appetite.

3.9 Review the controls and assurance against relevant quality risks on the Board Assurance Framework and provide assurance to the Board that risks to the annual objectives are being managed and facilitate the completion of the Annual Governance Statement at year end.

3.10 Obtain assurance that the Trust is compliant with guidance from NICE and other related bodies.

3.11 Consider external and internal assurance reports and monitor action plans in relation to clinical governance resulting from improvement reviews / notices from Monitor, the Care Quality Commission, the Health and Safety Executive and other external assessors.

Clinical Audit

3.12 Receive the annual clinical audit programme and provide assurance to the Board that clinical audit supports the divisions to provide safe and clinically effective patient care.

3.13 Obtain assurance that the clinical divisions deliver against their agreed annual clinical audit programme.

Communication

3.14 Oversee the communication of the trust's quality aspirations and objectives throughout the organisation.

4. MEMBERSHIP AND ATTENDANCE

4.1 The membership of the Committee shall consist of at least three Non-Executive Directors, together with the Chief Nurse and Director of Quality (Executive Lead), Chief Operating Officer and Medical Director. The committee meetings shall be open to all the members of the Board of Directors.

4.2 The Chief Nurse and Director of Quality will act as the lead executive director for the Committee.

Chair

4.3 The Chair of the committee will be the Trust chairman or non-executive director as determined by the Nominations Committee of the Board.

Attendees

4.4 Associate Medical Director for Patient Safety
Deputy Director of Risk, Governance and Patient Safety
Deputy Director of Nursing and Quality
Director of Infection Prevention and Control
Divisional Medical Directors

Quorum

4.5 Business will only be conducted if the meeting is quorate. The committee will be quorate with four members, including at least two Non-Executive Directors, and one Executive Director. If the Trust Chair is in attendance, this will count towards the quorum.

4.6 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Board of Directors meeting as an urgent item.

Attendance

4.7 The Chair and Lead Executive, or their nominated deputy, of the Committee will be expected to attend 100% of the meetings. Other Committee members will be required to attend a minimum of 80% of all meetings and be allowed to send a Deputy to one meeting per annum.

Attendance by Officers

4.8 The Committee will be open to the Chair, Chief Executive and Trust Secretary to attend.

4.9 Other staff may be co-opted to attend meetings as considered appropriate by the Committee on an ad hoc basis.

Voting

4.10 When a vote is requested, the question shall be determined by a majority of the votes of the members present. In the event of an equality of votes, the person presiding shall have a second or casting vote.

5. FREQUENCY

5.1 Meetings of the Committee shall generally be held monthly. The Chair may call additional meetings to ensure business is undertaken in a timely way.

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

6.2 Reference should be made as appropriate, to the Standing Orders and Standing Financial Instructions of the Trust.

6.3 The Committee has decision making powers with regard to the approval of clinical procedural documents.

6.4 The committee may set up permanent groups or time limited working groups to deal with specific issues. Precise terms of reference for these shall be determined by the committee. However, Board Committees are not entitled to further delegate their powers to other bodies, unless expressly authorised by the Trust Board (Standing Order 5.5 refers).

6.4 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary or advantageous to its work.

7 SERVICING ARRANGEMENTS

7.1 A member of the Board Secretariat shall attend meetings and take minutes.

7.2 Agendas and papers shall be distributed in accordance with deadlines agreed with the Committee Chair.

7.3 Members will be encouraged to comment via correspondence between meetings as appropriate.

7.4 The Committee will maintain a rolling annual work plan that will inform its agendas and seek to ensure that all duties are covered over the annual cycle. The planning of the meetings is the responsibility of the Chair.

8. ACCOUNTABILITY AND REPORTING

8.1 The Committee is accountable to the Board of Directors.

8.2 Chair reports will be provided to the Board of Directors to include: committee activity by exception; decisions made under its own delegated authority; any recommendations for decision; and any issues of significant concern.

8.3 Approved minutes will be circulated to the Board of Directors. Requests for copies of the minutes by a member of public or member of staff outside of the Committee membership will be considered in line with the Freedom of Information Act 2000.

9 RELATIONSHIPS WITH OTHER COMMITTEES

9.1 The Committee will receive minutes for scrutiny from the following meetings:

- Patient Safety Board
- Clinical Audit and Effectiveness Committee
- Patient Experience Group
- NICE Steering Group
- Single Oversight Meeting
- Clinical Support Services Divisional Governance Board
- Specialist Services Divisional Governance Board
- Surgical Services Divisional Governance Board
- Urgent Care and Long Term Conditions Governance Board

9.2 The Committee shall refer to the other Board Assurance Committees (the Integrated Audit Committee and the Finance and Investment Committee) matters considered by the Committee deemed relevant to their attention. The Committee, in turn, will consider matters referred to it by those two Assurance Committees.

9.3 The annual work plan of the Committee may be reviewed by the Integrated Audit Committee at any given time.

9.4 The Committee has links to the Council of Governors Patient and Staff Experience Committee

10. MONITORING EFFECTIVENESS AND REVIEW

10.1 The Committee will provide an annual report outlining the activities it has undertaken throughout the year.

10.2 A survey will be undertaken by the members on an annual basis to ensure that the terms of reference are being met and where they are not either; consideration and agreement to change the terms of reference is made or an action plan is put in place to ensure the terms of reference are met.

10.3 The terms of reference will be reviewed and approved by the Board of Directors on an annual basis.

Approved by the Board of Directors: April 2018

REPORT TO:	**COUNCIL OF GOVERNORS' MEETING**
DATE:	**3 AUGUST 2018**
SUBJECT:	**Report from the Chair of the Board of Directors' Strategic Workforce Committee**
REPORT FROM:	**Chair, Board of Directors' Strategic Workforce Committee** **Colin Tomson**
PURPOSE:	**DISCUSSION**

BACKGROUND AND EXECUTIVE SUMMARY

This report provides Council with a summary of the work of the Board of Directors' Strategic Workforce Committee (SWC). It is the first report since the Council agreed the new agenda structure whereby the Chair of each Board of Directors' Committee will report formally to Council twice a year. The report highlights how the NEDs on this Committee hold the Board to account for the quality of the services delivered.

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 discuss this report and take the opportunity to share with the Non-Executive Directors present intelligence arising from Governors' engagement with FT members and the public relevant to the work of the Committee as reported to the Trust Board.

Background

The Board of Directors' SWC meets on a bi-monthly basis. The Committee terms of reference are attached at Annex A.

The membership is as follows:

Members*:*
Colin Tomson, NED (Chair)
Wendy Cookson, NED (Clinical)
Jane Ollis, NED
Sandra Le Blanc, Director of HR
Sally Smith Chief Nurse & Director of Quality
Paul Stevens, Medical Director

Attendee at every meeting:
Bruce Campion-Smith, Head of Equality
Lee Martin, Interim Chief Operating Officer
Andrea Ashman, Deputy Director of HR
Alison Fox, Trust Secretary
Jane Christmas, Deputy Chief Nurse

Meetings are open to all members of the Board.

The Committee last met on 29 June 2018; a report of that meeting will go to the Board of Directors meeting scheduled for 10 August 2018. The report will be issued on 3 August and will be published on the Trust's website. The last report from the Committee to the Board went to the 8 June 2018 meeting and can be accessed via the link below:

https://www.ekhuft.nhs.uk/patients-and-visitors/about-us/boards-and-committees/the-board-of-directors/2018-board-of-directors-meetings/

Chair's report to Council

The Committee is responsible for providing the Board with assurance on all aspects relating to the workforce, including strategy, delivery, governance and risk management.

To deliver against this remit the Committee has the following items on all agendas.

- Updates from Committees which report into QC as part of the Trust's governance structure:
  - Local Negotiating Committee (LNC)
  - Staff Committee
  - Diversity and Inclusion Steering group
  - Integrated Education, Training and Leadership Development Board
  - Diversity and Inclusion Steering Group
- Integrated Performance report – workforce elements
- Statutory and mandatory training report

Other regular reports include:

Annually
- Staff survey results
- Strategic review of Equality/Race Equality Standard
- Provider Licence – annual statutory declaration
- Diversity and Inclusion Annual report
- Terms of reference review
- Committee Effectiveness Review

Six monthly
- People Strategy update
- Tribunal Activity report
- Medical Education
- Ward establishment review

Quarterly reports
- Staff turnover and online exit interviews
- Occupational health activity reports

My report to the Board meeting on 8 June summarised the Committee business during the June meeting. At the Board meeting itself I noted that the Trust was being affected by the Government's refusal to issue visas for overseas doctors. I advised the Board the Trust was technically in breach of the junior doctors' contract as not all exception reporting was being reviewed by a supervisor within seven days. Paul Stevens confirmed that this issue had now been resolved.

Unfortunately, I am unable to attend the Council meeting on 3 August. Jane Ollis has kindly agreed to step in to speak to this report and answer any questions you may have. I will also take this opportunity to wish the Council well for the future as my term of office will have been completed by your next meeting.

East Kent Hospitals University NHS Foundation Trust

STRATEGIC WORKFORCE COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Board of Directors has established a subcommittee of the Board known as the Strategic Workforce Committee. It is a Non-Executive committee and has no executive powers, other than those specifically delegated in these Terms of Reference. These Terms of Reference can only be amended with the approval with of the Board of Directors.

2. PURPOSE

2.1 The purpose of the committee is to provide advice , and make recommendations to the Board of Directors on all aspects of workforce and organisational development, and raise concern (if appropriate) on any workforce risks that are significant for escalating.

3. OBJECTIVES

3.1 Overseeing the development and implementation of the Trust's Human Resources Strategy, ensuring the Trust has robust recruitment and retention plans in place to support the delivery of high quality patient care and experience aligned to the Trust's strategic objectives.

3.2 Overseeing the development and implementation of the Trust's Education, Training, and Leadership Strategy to seek assurance on improved performance, return on investment and capability to deliver the Trust's strategic objectives particularly in relation to:

- Medical Education
- Clinical Productivity and Competency
- Professional and career development
- Skills development
- Apprenticeships
- Talent Management
- Leadership Development and Succession Planning

3.3 Ensuring that we as a Trust have in place Leadership development plans, which allow our leaders the time and relevant resources to progress 'change'. Clinical Leaders have time identified in their job plans to fulfil their non clinical lead responsibilities such as; management, educational, research etc.

3.4 Receiving reports relating to the creation and delivery of workforce plans aligned to Trust strategies, ensuring that the plans demonstrate the Trust has made provision for adequate staffing levels with the necessary skills and competencies to meet the future needs of patients and service users.

3.5 Ensuring the Trust continually reviews its workforce models (medical and non-medical), to reflect new roles and new ways of working to support delivery of the Trust's strategic objectives.

3.6 Ensuring that the Trust obtains the very best productivity through its medical and nursing workforce through effective job planning principles which safely obtains the maximum value of direct clinical care being provided to patients for all non training doctors and clinical practitioners.

3.7 Receive nursing staff establishment reviews to ensure that ward nursing staff establishments provide an appropriate staff level and skill mix to support the delivery of safe and effective patient care to patients.

3.8 To ensure that the Trust has appropriate pay, reward and recognition schemes that are linked to the delivery of the Trust's strategic objectives, outcomes and desired behaviours (linked to the culture change programme).

3.9 To oversee the Trust's Culture Change Programme including the outcomes of regular staff engagement surveys, and the effectiveness of the Trust's Communication and Engagement Strategy. Monitor the implementation of action plans to improve staff engagement.

3.10 Provide assurance to the Board that there are mechanisms in place for the staff to raise concerns and that these are dealt with in line with local policy and national guidance.

3.11 Monitor statutory and mandatory training compliance as defined in the Risk Management Training policy.

3.12 Consider the control and mitigation of workforce-related risks and provide assurance to the Board that such risks are being effectively controlled and managed.

3.13 That processes are in place to support the mental and physical well-being of staff

3.14 Ensuring that the Trust is compliant with relevant legislation relating to equality, diversity and human rights, including the Equality Diversity System 2 (for staff), and the NHS Workforce Race Equality Standard.

4. MEMBERSHIP AND ATTENDANCE

Members

4.1 The committee shall be appointed by the Board of Directors and shall comprise:

- Non –Executive Director (Chair)
- Non – Executive Director (Deputy Chair)
- Non – Executive Director
- Director of Human Resources
- Chief Nurse, Director of Quality
- Medical Director

4.2 The Director of Human Resources will act as lead executive director for the Committee.

Chair

4.3 The Chair of the committee will be the Trust chairman or non-executive director as determined by the Nominations Committee of the Board.

Attendees

To attend every meeting:

- Deputy Director of Human Resources
- Head of Diversity and Equality
- Chief Operating Officer or their nominee nominated Divisional Director)

To attend for specific reports as required:

- Director of Finance and Performance
- Head of Learning and Organisational Development
- Head of Corporate Human Resources
- Medical Education Director
- Associate Chief Nurse
- Lead Nurse - Occupational Health
- Director of Communications and Engagement
- Chair of Staffside

Quorum

4.4 Business will only be conducted if the meeting is quorate. The Committee will be quorate with at least two Non-Executive Directors and One Executive Director present. If the Trust Chair is in attendance, this will count towards the quorum.

4.5 If the meeting is not quorate the meeting can progress if those present determine. However, no business shall be transacted and items requiring approval may be submitted to the next Board of Directors meeting as an urgent item.

Attendance

4.6 The Chair and Lead Executive, or their nominated deputy, of the Committee will be expected to attend 100% of the meetings. Other Committee members will be required to attend a minimum of 80% of all meetings and be allowed to send a Deputy to one meeting per annum.

Attendance by Officers

4.7 The Committee will be open to the Chair, Chief Executive and Trust Secretary to attend.

4.8 Other staff may be co-opted to attend meetings as considered appropriate by the Committee on an ad hoc basis.

Voting

4.9 When a vote is requested, the question shall be determined by a majority of the votes of the members present. In the event of an equality of votes, the person presiding shall have a second or casting vote.

5. FREQUENCY

5.1 Meetings of the Committee shall generally be held bi-monthly. The Chair may call additional meetings to ensure business is undertaken in a timely way.

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

6.2 Reference should be made as appropriate, to the Standing Orders and Standing Financial Instructions of the Trust.

6.3 The committee may set up permanent groups or time limited working groups to deal with specific issues. Precise terms of reference for these shall be determined by the committee. However, Board Committees are not entitled to further delegate their powers to other bodies, unless expressly authorised by the Trust Board (Standing Order 5.5 refers).

6.4 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary or advantageous to its work.

7 SERVICING ARRANGEMENTS

7.1 A member of the Board Secretariat shall attend meetings and take minutes.

7.2 Agendas and papers shall be distributed in accordance with deadlines agreed with the Committee Chair.

7.3 Members will be encouraged to comment via correspondence between meetings as appropriate.

7.4 The Committee will maintain a rolling annual work plan that will inform its agendas and seek to ensure that all duties are covered over the annual cycle. The planning of the meetings is the responsibility of the Chair.

8 ACCOUNTABILITY AND REPORTING

8.1 The Committee is accountable to the Board of Directors.

8.2 Chair reports will be provided to the Board of Directors to include: committee activity by exception; decisions made under its own delegated authority; any recommendations for decision; and any issues of significant concern.

8.3 Approved minutes will be circulated to the Board of Directors. Requests for copies of the minutes by a member of public or member of staff outside of the Committee membership will be considered in line with the Freedom of Information Act 2000.

9 RELATIONSHIPS WITH OTHER COMMITTEES

9.1 The committee will receive minutes for scrutiny from the following meetings:

- Diversity and Inclusion Steering Group
- Medical Education
- Staff Committee
- Local Negotiating Committee
- Integrated Education Board

10. MONITORING EFFECTIVENESS AND REVIEW

10.1 The Committee will provide an annual report outlining the activities it has undertaken throughout the year.

10.2 A survey will be undertaken by the members on an annual basis to ensure that the terms of reference are being met and where they are not either; consideration and agreement to change the terms of reference is made or an action plan is put in place to ensure the terms of reference are met.

10.3 The terms of reference will be reviewed and approved by the Board of Directors on an annual basis.

April 2018

REPORT TO:	**COUNCIL OF GOVERNORS' MEETING**
DATE:	**3 AUGUST 2018**
SUBJECT:	**Report from the Chair of the Board of Directors' Integrated Audit and Governance Committee**
REPORT FROM:	**Chair, Board of Directors' Integrated Audit and Governance Committee** **Barry WIlding**
PURPOSE:	**DISCUSSION**

BACKGROUND AND EXECUTIVE SUMMARY

This report provides Council with a summary of the work of the Board of Directors' Integrated Audit and Governance Committee (IAGC). It is the first report since the Council agreed the new agenda structure whereby the Chair of each Board of Directors' Committee will report formally to Council twice a year. The report highlights how the NEDs on this Committee hold the Board to account for the quality of the services delivered.

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 discuss this report and take the opportunity to share with the Non-Executive Directors present intelligence arising from Governors' engagement with FT members and the public relevant to the work of the Committee as reported to the Trust Board.

Background

The Board of Directors' IAGC meets on a quarterley basis. The Committee terms of reference are attached at Annex A.

The membership is as follows:

Members:
Barry Wilding, NED (Chair)
Nigel Mansley, NED
Colin Tomson, NED
Keith Palmer, NED

Attendees:
Sally Smith, Chief Nurse & Director of Quality
Alison Fox, Trust Secretary
Helen Goodwin, Deputy Director of Risk, Governance and PatientSafety
Philip Cave, Director of Finance and Performance
External Audit
Internal Audit
Local Counter Fraud Services

The CEO attends the April meeting when the Committee considers the draft of the Trust's Annual Governance Statement.

The Committee last met on 27 April 2018; a report of that meeting went to the Board of Directors meeting held on 2018 and can be accessed via the link below:

https://www.ekhuft.nhs.uk/patients-and-visitors/about-us/boards-and-committees/the-board-of-directors/2018-board-of-directors-meetings/

The Committee meets next on 30 July and a report of that meeting will go to the Board of Directors meeting to be held on 10 August; the papers will be published on the Trust's website on 3 August.

There was a joint meeting of the IAGC, Quality Committee and Finance & Performance Committee on 11 May to consider and agree the Trust's Annual report, including the Trust's annual accounts.

Chair's report to Council

The Integrated Audit and Governance Committee (IAGC) is the high level committee with overarching responsibility for risk. The role of the IAGC is to scrutinise and review the Trust's systems of governance, risk management, and internal control. It reports to the Board of Directors (herein shown as the Board) on its work in support of the Annual Report, Quality Report, Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness of risk management arrangements, and the robustness of the self-assessment against Care Quality Commission (CQC) regulations.

To deliver against this remit the Committee has the following items on each agenda.

- Board Assurance Framework update
- Risk Register: Highest mitigating risks
- Freedom to speak up activity and training report
- Update report from External Auditors
- Update report from Internal Auditors
- Update from Counter Fraud officer

Other regular reports include:

Annually

- Review of Risk Management Policy
- Freedom of Information Act Annual Report
- Clinical Audit Plan
- Risk appetite
- Annual Risk Maturity Self-Assessment
- Letter of Declaration and Self-Assessment against NHS core standards for Emergency Preparedness, Resilience and Response.
- Standing Financial Instructions review
- Raising concerns report
- Review of Senior Managers risk management training compliance
- Gifts and Hospitality Annual Report
- Agree fees and annual plans for the following and receive annual report on performance for:
    - External audit
    - Internal audit - including the Head of Internal Audit Opinion
    - Counter Fraud
- Review policies on:
    - Non-core services
    - Counter fraud
- Committee terms of reference review
- Committee effectiveness review

Six monthly

- Update on the Information Governance Toolkit
- Losses and Special Payment report
- Single tender waiver report

My report to the Board meeting on 8 June summarised the Committee business during the 27 April meeting. The IAGC meeting scheduled for 30 July will be reported to the Board meeting on 10 August. In addition to the items due from the list above, the Committee will receive a deep dive report looking at the Cost Improvement Programme plans relating to patient flow. It is intended that the deep dives into the CIP will be a regular item on the IAGC agenda.

East Kent Hospitals University NHS Foundation Trust

INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC)

TERMS OF REFERENCE

1 CONSTITUTION

1.1 The Board of Directors has established a committee of the Board known as the Integrated Audit and Governance Committee. It is a Non-Executive committee and has no executive powers, other than those specifically delegated in these Terms of Reference. These Terms of Reference can only be amended with the approval of the Board of Directors.

2 PURPOSE

2.1 The Integrated Audit and Governance Committee (IAGC) is the high level committee with overarching responsibility for risk. The role of the IAGC is to scrutinise and review the Trust's systems of governance, risk management, and internal control. It reports to the Board of Directors (herein shown as the Board) on its work in support of the Annual Report, Quality Report, Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness of risk management arrangements, and the robustness of the self-assessment against CQC regulations. Its key responsibilities are to:

2.1.1 monitor the integrity of the financial statements of the Trust, and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained in them;

2.1.2 review the Trust's internal controls (clinical and financial) and risk management systems;

2.1.3 review and monitor the external auditor's independence and objectivity and the effectiveness of the external audit process, including approval of annual plans, taking into consideration relevant UK professional and regulatory requirements;

2.1.4 make recommendations to the Council of Governors regarding the appointment, re-appointment and removal of the external auditor, including tender procedures;

2.1.5 develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm;

2.1.6 monitor and review the effectiveness of the Trust's internal audit function and counter-fraud arrangements, including approval and review of related annual plans;

2.1.7 approve the appointment and/or removal of the internal auditors;

2.1.8 report to the Council of Governors, identifying any matters in respect of which it considers that action or improvement is needed, making recommendations as to the steps to be taken;

2.1.9 produce an annual report for the Board of Directors

2.1.10 review arrangements by which staff within the Trust may raise confidentially concerns over financial control and reporting, clinical quality and patient safety and other matters.

3 OBJECTIVES

Governance, Risk Management and Internal Control

3.1 The IAGC shall review the establishment and maintenance of an effective system of integrated governance, risk management, internal control (clinical and non-clinical) across the whole of the organisation activities that supports the achievement of the Trust's objectives.

In particular, the committee will review the adequacy of:

3.2 all risk and control related disclosure statements (in particular the Annual Governance Statement, regular reports on the activities of the Risk Management and Governance Committee, self-certification statements to the Regulator, and Care Quality Commission declarations), together with any accompanying Head of Internal Audit statement, External Auditor opinion or other appropriate independent assurances, prior to endorsement by the Board.

3.3 underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

3.4 The IAGC will undertake periodic review of progress against the Board Assurance Framework and Corporate Risk Register, with significant changes highlighted. Where these items are of such a significant nature, 4.2 refers, the Chair of the IAGC will bring them to the immediate attention of the chair of the Board of Directors. A full copy of these key documents will be made available to the IAGC in accordance with the timetable agreed by the Board and will normally be reviewed in full prior to the production of the Annual Report and Accounts and the Annual Governance Statement and as part of the Trust's mid year review process.

3.5 policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications, and consider any training requirements to ensure committee members are kept up to date with emerging requirements.

3.6 policies and procedures for all work related to counter fraud and security as required by NHS Counter Fraud Authority.

3.7 arrangements by which staff of the Trust may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters, with the aim of ensuring that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

3.8 In carrying out this work the committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

3.9 This will be evidenced through the committee's use of an effective Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

3.10 As part of its integrated approach, the Committee will have effective relationships with other key committees so that it understands processes and linkages. However, these other committee's must not usurp the Committee's role.

External Audit

3.11 The Council of Governors will take the lead in agreeing with the IAGC the criteria for appointing, reappointing and removing auditors. The IAGC will make recommendations to the Council of Governors on these matters, and approve the remuneration and terms of engagement of the External Auditor. In accordance with its Standing Orders, the Council of Governors will appoint the external auditor following recommendation from the IAGC.

3.12 The IAGC shall develop and implement policy, in collaboration with the Finance and Performance Management Directorate, regarding the engagement of the External Auditor to supply non-audit services, taking into account relevant ethical guidance. All requests for the supply of non-audit services must be presented to the IAGC for noting.

3.13 The IAGC shall review and monitor the External Auditor's independence and objectivity, and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements.

3.14 The IAGC shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

3.14.1 consideration of the appointment and performance of the External Auditor, as far as the rules governing the appointment permit.

3.14.2 review and agreement, before the audit commences, the nature and scope of the audit as set out in the annual external audit plan.

3.14.3 discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.

3.14.4 review of all audit reports that are specifically drawn to the attention of the IAGC by the auditors which will include the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

3.14.5 Ensuring that there is in place a clear policy for the engagement of external auditors to supply non audit services.

3.14.6 The Head of External Audit will have unhindered and confidential access to the Chair of the IAGC.

Internal Audit

3.15 The IAGC shall ensure that there is an effective Internal Audit function established by management that meets the Public Sector Internal Audit Standards, 2013 and provides appropriate independent assurance to the IAGC, Chief Executive and Board. This will be achieved by:

3.15.1 consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;

3.15.2 review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework;

3.15.3 where there is a requirement to undertake work outside of the approved annual work plan, all such requests must be presented to the IAGC for approval;

3.15.4 consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources;

3.15.5 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;

3.15.6 annual review of the effectiveness of internal audit in such manner as is appropriate and agreed by the IAGC, including a review of the successful operation of the contract between the Trust and Internal Audit.

3.15.7 The Head of Internal Audit will have unhindered and confidential access to the Chair of the IAGC.

Other Assurance Functions

3.16 The IAGC shall review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications for the governance of the organisation. These will include, but not be limited to, any review by Department of Health arms-length bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Resolution, Monitor etc.), and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies etc.).

Counter Fraud

3.17 The IAGC shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Counter Fraud Authority's standards and shall review the outcomes of work in these areas.

Management

3.18 The IAGC shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

3.19 They may also request reports from individual functions within the Trust (e.g. clinical audit) as they may be appropriate to the overall arrangements.

Financial Reporting

3.20 The IAGC will monitor the integrity of the financial statements of the Trust, and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained in them. In doing so, the IAGC shall additionally utilise the findings of the Finance and Performance Committee, which is chaired by a Non-Executive Director of the Trust Board.

3.21 The IAGC shall review the Annual Report and Accounts before submission to the Board, focusing particularly on:

3.21.1 changes in, and compliance with, accounting policies and practices and estimation techniques;

3.21.2 major judgemental areas;

3.21.3 significant judgements in the preparation of the financial statements;

3.21.4 significant adjustments resulting from the audit;

3.21.5 the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the IAGC;

3.21.6 letters of representation;

3.21.7 explanations for significant variances;

3.21.8 unadjusted mis-statements in the financial statements.

3.21.9 Providing mandatory issues (as detailed in paragraph 1) are reserved for the attention of the full committee in session, other matters including review of the Annual Report and Summary Financial Statements may be dealt with as the IAGC deems appropriate through a process coordinated by the IAGC Chair.

3.22 The IAGC should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

4. MEMBERSHIP AND ATTENDANCE

Membership

4.1 The IAGC shall consist of not less than 4 Non Executive Director members. There will be appropriate cross-membership with other Board committees.

4.2 One member of the IAGC should have significant, recent and relevant financial experience as outlined in the Combined Code and Sarbanes-Oxley Act 2002. The Chair of the Trust shall not be a member of the IAGC.

Chair

4.3 The Chair of the committee will be a non-executive director as determined by the Nominations Committee of the Board.

Attendees

4.4 External and Internal Auditors the Head of Clinical Audit and a representative of the counter-fraud specialists are required to make themselves available when required for a private meeting with the IAGC Chair immediately prior to each IAGC meeting.

4.5 The Finance Director, Chief Nurse and Director of Quality, Trust Secretary and appropriate Internal and External Audit and counter-fraud representatives shall normally attend IAGC meetings.

4.6 The Chief Executive and other executive directors may be invited to attend, particularly when the IAGC is discussing areas of risk or operation that are the responsibility of that director.

4.7 The Chief Executive should be invited to attend, at least annually, to discuss with the IAGC the process for assurance that supports the Annual Governance Statement. He or she should also attend when the Committee considers the draft Annual Governance Statement and the Annual Report and Accounts.

Quorum

4.8 Business will only be conducted if the meeting is quorate. The Committee will be quorate with at least two Non-Executive Directors present. If the Trust Chair is in attendance, this will count towards the quorum.

4.9 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Board of Directors meeting as an urgent item.

Attendance by Members

4.10 The Chair, or their nominated deputy, of the Committee will be expected to attend 100% of the meetings. Other Committee members will be required to attend a minimum of 80% of all meetings and be allowed to send a Deputy to one meeting per annum.

Attendance by Officers

4.11 The Committee will be open to the Chair, Chief Executive and Trust Secretary to attend.

4.12 Other staff may be co-opted to attend meetings as considered appropriate by the Committee on an ad hoc basis

Voting

4.13 When a vote is requested, the question shall be determined by a majority of the votes of the members present for the item. In the event of an equality of votes, the person presiding shall have a second or casting vote.

5 FREQUENCY OF MEETINGS

5.1 Meetings shall be held quarterly. The Board, Chief Executive, External Auditor or Head of Internal Audit may request a meeting to ensure business is conducted in a timely way.

6 AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

6.2 Reference should be made as appropriate, to the Standing Orders and Standing Financial Instructions of the Trust.

6.3 The committee may set up permanent groups or time limited working groups to deal with specific issues. Precise terms of reference for these shall be determined by the committee. However, Board Committees are not entitled to further delegate their powers to other bodies, unless expressly authorised by the Trust Board (Standing Order 5.5 refers).

6.4 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary or advantageous to its work.

7. SERVICING ARRANGEMENTS

7.1 A member of the Board Secretariat shall attend meetings and take minutes.

7.2 Agendas and papers shall be distributed in accordance with deadlines agreed with the Committee Chair.

7.3 Members will be encouraged to comment via correspondence between meetings as appropriate.

7.4 The IAGC will maintain a rolling annual work plan that will inform its agendas and seek to ensure that all duties are covered over the annual cycle.

8 ACCOUNTABILITY AND REPORTING

8.1 The Committee is accountable to the Board of Directors.

8.2 Chair reports will be provided to the Board of Directors to include: committee activity by exception; decisions made under its own delegated authority; any recommendations for decision; and any issues of significant concern.

8.3 Approved minutes will be circulated to the Board of Directors. Requests for copies of the minutes by a member of public or member of staff outside of the Committee membership will be considered in line with the Freedom of Information Act 2000.

9 RELATIONSHIPS WITH OTHER COMMITTEES

9.1 The Committee will receive minutes for scrutiny from the following meetings:

- Information Governance Steering Group
- Information Assurance Board

9.2 Alignment with Council of Governor Audit Working Group

10 MONITORING EFFECTIVENESS AND REVIEW

10.1 The Committee will provide an annual report outlining the activities it has undertaken throughout the year.

10.2 A survey will be undertaken by the members on an annual basis to ensure that the terms of reference are being met and where they are not either; consideration and agreement to change the terms of reference is made or an action plan is put in place to ensure the terms of reference are met.

10.3 The terms of reference will be reviewed and approved by the Board of Directors on an annual basis.

11.3 The IAGC shall report to the Council of Governors, identifying any matters within the Council's remit in respect of which it considers that action or improvement is needed, and making recommendations as to the steps to be taken.

11. JOINT COMMITTEES

11.1 The IAGC shall meet annually in May, jointly with the Finance and Performance Committee (FPC) for the purpose of reviewing the annual report and accounts, and annual plan, prior to formal approval by the Board of Directors.

11.2 Other joint meetings with the FPC shall be held from time to time as agreed between the Chair of the FPC, the Chair of the IAGC, Trust Chairman, Trust Chief Executive and Executive Directors, for the purpose of reviewing Divisional performance and for such other matters as may be agreed by both Committees within their respective Terms of Reference.

11.3 Meetings shall be chaired jointly unless otherwise agreed by the Chairs of both committees.

11.4 All members of the IAGC and FPC shall be members of the Joint Committee. Attendance by others will be by invitation but will normally include the Deputy Finance Director and Deputy Director of Risk and Governance.

11.5 A quorum shall comprise Chairs of both the IAGC and FPC, the Director of Finance and Performance Management and the Chief Nurse/Director of Quality and Operations.

11.6 In all other regards the Joint Committee will operate and be administered in the same manner as set out in each Committee's individual Terms of Reference.

Reviewed by the Committee: JANUARY 2018

Approved by the Board of Directors: FEBRUARY 2018

REPORT TO:	**COUNCIL OF GOVERNORS' MEETING**
DATE:	**3 AUGUST 2018**
SUBJECT:	**MEMBERSHIP ENGAGEMENT AND COMMUNICATION COMMITTEE (MECC) CHAIR'S REPORT**
REPORT FROM:	**Chair, MECC** **PHILIP BULL**
PURPOSE:	**DISCUSSION**

BACKGROUND AND EXECUTIVE SUMMARY

This report provides a summary of the key items discussed at the two MECC meetings held since the last meeting of the Council of Governors; 18 May and 30 July 2018.

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 content of this report.

Chair's Report

The meeting held on 18 May was the first for the new Committee following the annual review of CoG committee membership. The Committee wishes to bring the following items to the attention of Council.

Annual Members Meeting (AMM)

The AMM is being held on 10 September at the Spitfire Cricket Ground, Canterbury, starting with a Market Place from 5.30pm and the meeting proper beginning at 6.30pm. The theme of the AMM will be Child Health and Learning Development. A small team over sees the event:

- Alison, as Trust Secretary;
- Natalie for Communications;
- Mandy Carliell for the market place;
- Amanda for the membership; and
- myself to represent the Council

There are some statutory items which have to be included on the agenda for the meeting proper, which includes the receiving of the Trust's Annual Report. Reports would be given by the Chair, the executive team and the Lead Governor for Council. Presentations from clinicians will also be part of the agenda this year. MECC discussed the importance of being open and transparent with the public and members and providing a balanced view about the services provided. Some services provided by the Trust were recognised as leaders in the field and this should be highlighted alongside recognition of where improvements were needed. The AMM needed to provide assurance to the public.

The Committee considered whether the 'questions' section of the meeting could be better managed. Asking attendees to submit questions in writing on the night was suggested as

this would help ensure that everyone had a chance to pose a question and an opportunity to put individual questions into topic groups for answering. If this was done, it was important that all the questions submitted received an answer at the meeting. The Committee felt that there should also be opportunity for spontaneous questions and recognised the importance of the role of the Chair in managing this.

It was agreed that questions about care provided to an individual were not appropriate for a public forum; the PALs team and senior members of staff would be available on the night to deal with these separately.

There will be a 'Meet the Governor' stall at the Market Place and Governors will be asked to help at the reception area and in directing attendees. Amanda will liaise with Governors before the meeting to agree roles and will provide a briefing prior to the meeting so that governors were clear about their roles.

Membership and Member feedback

At each meeting the Committee receive a summary report on changes in the membership and engagement with members and the public.

It is planned that current members who have not provided an email address will be contacted by post in August to ask them to confirm that they wish to remain as members and, where possible, to provide an email address. This will result in a drop in public3 membership, but an increase in the proportion that can be communicated with electronically. Members will still have the opportunity to opt to be on a 'post only' distribution list so that they receive hard copy communications from the Trust. Once this exercise is completed plans will be agreed for membership recruitment; this can be targeted towards improving the demographic balance within the membership so that it properly reflects the community which the Trust serves.

At the July meeting there was some discussion about how concerns raised with Governors by members and the public were brought to the attention of Council. It was recognised that Governors were able to record feedback they received via the database managed by the Governor and Membership Lead and that this allowed themes and trends to be identified. Governors were also able to use the monthly meetings held between the Lead Governor and the Trust Chair to raise particular concerns.

It was noted that it was critical for Governors to direct those who raised concerns about care being provided to an individual patient to the PALs team. Governors commented that making contact with the PALs team could be difficult with phones not being answered and messages left not being returned. The Committee asked that assurance be provided that contacts with the PALs team were being responded to in an appropriate manner.

Two areas of quality of care were raised at the meeting:

- Outpatient appointments – there were several examples given of patients attending for appointments which had been cancelled.
- Patient information following the fitting of pacemakers.

These were brought to the attention of a governor while working in a volunteer role, which prompted an action to request assurance that there was a mechanism for intelligence gathered by volunteers to be captured by the Trust.

Council Membership and Members' Engagement Strategy

At the July meeting the Committee noted that the current strategy runs up to August 2019. It agreed the following work plan for delivering a draft strategy for September 2019 – August 2022 for ratification by the August 2019 Council meeting.

- MECC July 2018 – agree workplan and seek volunteers to be part of a small task and finish group
- MECC October 2018 – confirm membership of the task and finish group. AB to present an analysis of performance against the current structure, Committee to look at this and decide on some principles to guide the small team to produce a proposed structure for the new strategy.
- MECC January 2019 – agree the structure of the new strategy for task and finish group to populate
- CoG February 2019 – structure of the new strategy to be considered by Council
- MECC April 2019 – look at first draft of the strategy and comment
- CoG May 2019 – comment on first draft of strategy
- MECC July – agree the final draft
- CoG August – draft presented for ratification

During the meeting it was agreed that the task and finish group needed to include the use of social media and the amount of engagement work that governors could reasonably sustain in their deliberations.

Governor newsletter (GNL)

The Committee spent some time discussing how to make the GNL more relevant and interesting. It was agreed that the aim should be to inform members about the work of the Council. Editions should be published when there was news to tell, rather than on a regular basis and the presentation needed to improve.

An edition would be sent by the end of August to cover the recent Meet the off site Governor events, and publicise the last two events in the pilot project, as well as the new programme of Joint Site visits, including actions which had been taken following the visits. The edition would also give details of the AMM.

REPORT TO:	**COUNCIL OF GOVERNORS' MEETING**
DATE:	**3 AUGUST 2018**
SUBJECT:	**TASK AND FINISH GROUP – CONSTITUTION REVIEW AND GOVERNOR ROLE DOCUMENT**
REPORT FROM:	**TRUST SECRETARY** **ALISON FOX**
PURPOSE:	**APPROVAL**

BACKGROUND AND EXECUTIVE SUMMARY

This report updates the Council on the work of the Task and Finish group set up to review the Trust's Constitution and consider whether the Code of Conduct and the Role of the Governor documents should be combined within the constitution.

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:

a) agree the proposed changes to the Constitution; and
b) note the plans to replace the Roles of a Governor document with a Council Responsibilities Pack and a revised Code of Conduct.

Background

At the Joint Governor and NED meeting on 15 February it was requested that consideration be given to whether the following documents should be combined:

- Trust Constitution
- Code of Conduct
- Role of a Governor.

This question arose as a result of the amount of overlap identified between these documents during the discussion on setting up the task and finish group. It is also recognised that the purpose of the Role of a Governor document is to assist the Council to understand its role; the complexity of the document does not support this purpose.

A draft terms of reference (Annex A) and scoping paper (Annex B) were circulated to the group in preparation for a meeting to be held on 24 June. A formal meeting did not take place due to constraints of time, however the group agreed that the course of action laid out in the scoping paper was appropriate and that the group would meet formally on 11 July 2018.

Position Update

The Task and Finish group agreed that the terms of reference would best be met by following two work streams.

Work stream A – Constitutional Changes

Agree the changes to be proposed to Council at the 11 July meeting, take these to the Council meeting on 3 August. The Council approved changes would then be taken to the Board meeting on 10 August for approval. These can then be taken to the Annual Members' meeting on 10 September.

The changes being proposed by the Task and Finish Group are listed below.

Work stream B – Council Responsibilities Document

The Task and Finish group looked at a proposal for the content of the Council Responsibilities pack – Annex C. They considered that would provide a useful induction and reference document for Council. In developing the document various policies relating to the Council's work would be reviewed and revised or updated.

It was agreed that a first draft of the full document would be produced by the Governor and Membership Lead for consideration at a meeting of the Task and Finish Group in October. A final draft would be completed in time for an item to go to the Council meeting on 6 November to approve the document. The final draft would include a proposal for a revised Code of Conduct cross referenced to the Council Responsibilities Pack.

Changes proposed to the Trust's Constitution

A. Page 21 section 49.3 under Mergers etc and significant transactions

Diagram 1, Significant transaction frame work (below) to be replaced with the wording:
'A significant transaction is one which is deemed to be a significant transaction by NHS Improvements.'

		Reporting requirements	
Ratio	Description	Non-healthcare/ International	UK Healthcare
Assets	The gross assets* subject to the Transaction, divided by the gross assets of the foundation trust	> 5%	> 10%
Income	The income attributable to: • the assets; or • the contract associated with the Transaction, divided by the income of the foundation trust	> 5%	> 10%
Consideration to total foundation trust capital	The gross capital** or consideration associated with the Transaction divided by the total capital*** of the foundation trust following completion, or the effects on the total capital of the foundation trust resulting from a Transaction	> 5%	> 10%

* Gross assets is the total of fixed assets and current assets
** Gross capital equals the market value of the target's shares and debt securities, plus the excess of current liabilities over current assets
*** Total capital of the foundation trust equals taxpayers' equity

B. Page 26 Composition of Council.

Replacing Thanet District Council with Folkestone and Hythe District Council following the formal renaming of the district council.

C. Page 81 Annex 7 2.1 Composition of the Council

It is proposed that the following paragraph:

> If a Governor resigns from office as Lead Governor then the Council of Governors shall thereupon elect another Governor as the Lead Governor without delay. Any such Governor shall serve as the Lead Governor for one year from the date at which he/she is elected by the Council of Governors.

be changed to:

> If a Governor resigns from office as Lead Governor, or dies in service, then the Council of Governors shall thereupon elect another Governor as the Lead Governor without delay. Any such Governor shall complete the term of office of the lead Governor they suceeed.

This will ensure that the election of the Lead Governor stays within the same timeframe as the Governor elections.

D. Page 82 Annex 7 section 3.1 Calling meetings

The section currently reads:

> The Chairman may call meetings of the Council of Governors. If the Chairman refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of governors including at least two elected and two appointed governors, has been presented to him/her, or if, without so refusing, the Chairman does not call a meeting within 14 days after such requisition has been presented to him/her, at the Trust's Headquarters, such one third or more governors may forthwith call a meeting of the Board.

It is proposed that the number of appointed governors be reduced to 'at least one' given that the size of the Council has been reduced from 26 to 19 and there are now only 3 appointed governors.

E. Page 87 Annex 7 section 3.12 Virtual voting

The section:

> In the event that a decision is required ahead of the next Council of Governors meeting a virtual vote will be proposed. The vote will be passed if 65% of Governors vote for the motion and at least 50% of the elected and appointed Governors has voted. The decision will be ratified at the next public Council of Governors meeting.

To be changed to

> In the event that a decision is required ahead of the next Council of Governors meeting a virtual vote will be proposed. The vote will be passed if 65% of Governors vote for the motion and at least 70% of all governors able to vote. The decision will be ratified at the next public Council of Governors meeting.

F. page 97 Appendix 1 to Council of Governors Standing Orders

The index provides links to internal and external documents relevant to the Council of Governors. It is proposed to delete this appendix as the information contained in

the index will be included in the Council Responsibilities Pack – which can more easily be kept up to date.

East Kent Hospitals University NHS Foundation Trust

COUNCIL OF GOVERNORS TASK AND FINISH GROUP
Trust Constitution and Governor Roles Document

Terms of Reference

The Task and Finish Group was established at the Joint Governor and Non-Executive Directors meeting on 15 February 2018 and is asked to:

- Review and update the Trust's Constitution; and
- Consider whether the following documents should be combined:
    - Trust Constitution
    - Code of Conduct
    - Role of a Governor

The Group will consist of:

- Governors:
    - John Bridle
    - Sharon Hatfield-Tugwell
    - Ken Rogers
- Alison Fox, Trust Secretary
- Barry Wilding, Chair of the Board of Directors' Integrated Audit and Governance Committee
- Amanda Bedford, Governor and Membership Lead

East Kent Hospitals University NHS Foundation Trust

COUNCIL OF GOVERNORS TASK AND FINISH GROUP
Trust Constitution and Role of a Governor Document Review

PROPOSAL PAPER
At the meeting on 15 February it was requested that consideration be given to whether the following documents should be combined:

- Trust Constitution
- Code of Conduct
- Role of a Governor.

This question arose as a result of the amount of overlap identified between these documents during the discussion on setting up the task and finish group. It is also recognised that the purpose of the Role of a Governor document is to assist the Council to understand its role; the complexity of the document does not support this purpose.

It is therefore proposed that the documents are not combined and the Task and Finish Group move forward on that basis, taking the following action:

- Trust Constitution
  This is effectively the Trust's governance rule book and is based on the accepted national model. The Task and Finish Group should review the content and:

  - update it for any changes needed to respond to organisational change, such as the name change made by the Shepway District Council, which is now the Folkestone and Hythe District Council
  - Remove links to documents as these can become out-dated
  - Consider whether there are any changes needed to allow the Trust to operate more effectively. The following issues have been identified for consideration since the last review of the constitution:
    - Annex 7 section 3.12 and Annex 8 Section 3.21 – virtual voting rules. Are the criteria for passing the vote appropriate.
    - Annex 7 section 2.1 – length of term of the Lead Governor when there is a resignation mid-term. Currently the 'replacement governor' will serve a full year, it is proposed that this be changed to completing the term of office of the governor who resigned from the post. This will ensure that the annual timing of the Lead Governor elections remains constant and fits to the Council election and CoG Committee membership cycle.

- Roles of a Governor
  It is proposed that this document is replaced with a document which summarises the responsibilities of the Council, with appropriate cross referencing to the Monitor Guide and the Trust Constitution. The Group should consider whether the appropriate policy or guidance exists, or needs to be developed, to support the Council to deliver that role. The summary with the related policies and guidance would form a Council Responsibilities Pack and this could provide the basis of an induction pack for new Governors.

- Code of Conduct
  It is proposed that the Group should then revise the Code of Conduct on the basis of the work undertaken to create the new Council Responsibilities Pack.

Work plan

If the proposals above are agreed, then the Task and Finish Group has two work streams:

A. To review the Constitution

B. To create a Council Responsibilities Document and review the Code of Conduct in light of that document.

Work stream A plan

This needs to be completed to a timeframe which ensures that any changes proposed can be presented to the Annual Members meeting on 10 September. The work plan for this would be as previously suggested:

- 6 July – issue draft of revised constitution to T&F group
- 11 July – T&F Group meeting – to discuss and agree the draft changes
- By 26 July – virtual agreement of the final proposals for changes. These will have been shared with the Trust Chair for approval.
- 27 July – paper recommending changes to Council sent with agenda for 3 August public meeting
- 3 August – Council meeting which will consider the recommendations
- 10 August – Board meeting to consider the recommendations if the Council approves the changes
- 10 September – Changes presented to the AMM if the Board has approved.

Work stream B plan

- 11 July – T&F Group meeting to consider a draft framework for what the Council Responsibilities Document (CRD) will look like and agree the policies and guidance which are needed to support the Council to deliver on their duties.

  An update report from the Group to go to the Council meeting on 3 August for their approval of the process.

- Week 1 October – meeting of the T&F Group to consider a full draft of the CRD and associated policies and guidance. The Code of Conduct document to be reviewed in light of this draft and agreement reached on the changes which are needed.
- By 26 October – virtual agreement achieved for the CRD and revised Code of Conduct. These will have been shared with the Trust Chair for approval.
- 30 October – paper to be issued to Council
- 6 November – Council meeting to consider and agree the drafts.

Council Responsibilities Pack

Index

Summary of the Role of Council and Governors

Note: **bold and red** indicates a document which included in the pack (see index page to locate)

The Council of Governors (CoG) has two key responsibilities:

- Representing the interests of members and the public
- Holding the Non-Executive Directors to account for the performance of the Board

The overriding duty of the Board of Directors is to be collectively and individually responsible for promoting the success of the FT so as to maximise the benefits for the members of the FT as a whole and for the public, particularly when they are patients of the FT.

This means the BoD is focused on providing high quality health care to the FT members and communities it serves.

The BoD is therefore responsible for the direction and performance of the Trust, while the CoG is primarily responsible for assuring the performance of the BoD in discharging its responsibilities.

It is important that both the CoG and BoD see their interaction as primarily being one of constructive partnership. The BoD and CoG should seek to work effectively together and avoid unconstructive adversarial interaction.

Governors are required to meet the same **Fit and Proper Persons Test** required of Trust Board members, and to adhere to **The Code of Conduct for Governors.**

The CoG as a whole, has the responsibilities and powers in statute and not individual Governors. Though governors hold NEDs to account this does not mean that Governors are responsible for decisions taken by the BoD on behalf of the Trust. The CoG cannot delegate its powers to a Committee – all decisions must be taken at Full Council meetings.

The CoG has a number of duties laid out in statute and these are summarised in the **Governor Statutory Duties Guide**, which contains cross references to the **statutory guidance documents**.

Governors do not have the right to inspect FT property or services nor do they have a duty to meet patients and conduct quality reviews.

GOVERNOR STATUTORY DUTIES

Council's main statutory duties are:

- To hold the Non-Executive Directors (NEDs) individually and collectively to account for the performance of the Board of Directors
- To represent the interests of the members of the trust as a whole and the interests of the public

Constitution: 18.1 Monitor Guidance: XX

The following table summarises the Council's duties as laid out in statute and the Trust's constitution.

The route explains how the Council delivers the responsibility with the relevant sections of statute or guidance provided in the references column and the relevant Trust documents listed in the final column.

Statutory Duty	**Summary**	**Route**	**References**	**Trust Documents** To locate see pack index
Appointment and Remuneration				
Appointing the Trust Chair & Non-Executive Directors (NEDs).	The CoG is responsible for appointing the Trust chair and the NEDs. Support is provided from the Trust's HR team and Governor and Membership Lead (GML). For NED appointments the Trust Chair advises on skills and experience needed to fill current gaps on the Board. The Senior Independent Director chairs the Appointment Panel for the Trust Chair, for NED	Process carried out by the CoG Nomination and Remuneration Committee Recommendation made to Council for approval.	Constitution: 28.1 & 28.3 Monitor: XX	Terms of Reference: CoG Nomination and Remuneration Committee Policy: Guide to the Appointment of the Trust Chairman and Non-Executive Directors of the Board

	appointments the panel is chaired by the Trust Chair.			
Removing the Trust Chair & Non-Executive Directors.	The Council can remove the Trust Chair and NEDs. Monitor Guidance states that removal is likely to be appropriate only in very limited and particular circumstances as a last resort.	At Council meeting	Constitution: 28.2 Monitor: XX	CURRENTLY THE INFORMATION IS CONTAINED IN THE DUTIES DOCUMENT. A GUIDANCE DOCUMENT SHOULD BE CREATED.
Remuneration of Trust Chair and NEDs				
Appointing/removing Trust external auditor				
Approving/not approving the appointment of the Chief Executive Officer.				
Appraisal				
To contribute to and receive the results of the Senior Independent Director's annual appraisal of the Trust Chair's performance.				
To contribute to and receive the results of the Chair's annual appraisal of the NEDs individual performances.				
Finance and Business Development				
Receiving annual report				

and accounts				
Receiving auditor's report				
Approving/Not approving increases to to non-NHS income of more than 5% of total income a year				
Approving/not approving acquisitions, mergers, separations and dissolutions				
Approving/not approving significant transactions				
Expressing a view on board's forward plans in advance of submission to NHS Improvement				
Approving Changes to the Constitution				
Jointly approving, with the Board, changes to Trust's constitution.				

How the Council of Governors works
Note: **bold and red** indicates a document which included in the pack
(see index page to locate)

Composition

The Council consist of 19 Governors:

- 13 elected public governors
  - Ashford – 2
  - Canterbury - 2
  - Dover – 2
  - Folkestone & Hythe – 2
  - Swale – 2
  - Thanet – 2
  - Rest of England and Wales - 1

- 3 elected staff governors

- 3 appointed partner governors
  - Local Authorities representative
  - Universities representative
  - Volunteers

See the **Board and Council Chart** for current incumbents.

Lead Governor

DESCRIPTION OF ROLE,

Your individual responsibilities as a Governor

- DETAILS OF CODE OF CONDUCT
- CONFIDENTIALITY
- MINIMUM ATTENDANCE AT MEETING
- FIT AND PROPER PERSONS including annual re-affirmation and requirement to declare any new information which might impact on a DBS clearance
- REGISTER OF INTERESTS (link to web)
- CONFLICT OF INTERESTS
- ADHERING TO TRUST VISION, MISSION AND VALUES

Training

ADD IN DETAILS

Council of Governors Committee Structure

- STRUCTURE
- COUNCIL MEETING PATTERN/AGENDA SCHEDULE
- MEMBERSHIP ON COMMITTEES: WHAT AND HOW DECIDED

Assessing Council Effectiveness

DETAILS OF ANNUAL PROCESS

Housekeeping

- Communication with Governors
  USE OF NHS.NET
  ISSUING PAPERS
  PUBLIC BOARD MEETINGS
  TRUST WEBSITE
  STAFF ZONE
  CROSS REF TO MEDIA POLICY

- Claiming expenses
  ADD IN DETAILS

- Parking
  ADD IN DETAILS

The Board of Directors

Note: **bold and red** indicates a document which is included in the pack (see index page to locate)

Composition

The Board consists of Executive Directors (EDs), who hold operational positions within the Trust, and Non-Executive Directors (NEDs), who are appointed by the Council of Governors and do not have an operational role within the organisation. Together, as the Board of Directors (BoD), the EDs and NEDs have a legal responsibility for the performance of the Trust.

There are eight NEDs on the Board, including the Trust Chair. One NED is designated as the Deputy Chairman and one as the Senior Independent Director (SID). NEDs are chosen to provide the Board with a wide range of skills and usually have a professional working background with extensive experience in their chosen field. NEDs will normally have links to the East Kent area.

There are seven Executive Directors on the Board:

- Chief Executive Officer
- Director of Strategic Development and Capital Planning
- Director of Finance and Performance
- Medical Director
- Chief Nurse and Director of Quality
- Chief Operating Officer
- Director of Human Resources

See the **Board and Council Chart** for current incumbents.

Trust Mission, Vision and Values

ADD IN, including context

Strategic Objectives

ADD IN, including context

Board Committee Structure

ADD IN DETAILS