MINUTES FROM THE TWENTY-FOURTH PUBLIC MEETING OF THE COUNCIL OF GOVERNORS MONDAY 10 MARCH 2014, THE ARK, DOVER

PRESENT:

Nicholas Wells	Chairman	NW
David Bogard	Elected Staff Governor	DB
Mandy Carliell	Elected Staff Governor	MC
Professor Alan Colchester	Elected Staff Governor	AC
Jocelyn Craig	Elected Governor – Ashford	JC
Geraint Davies	Nominated Governor – South East Coast Ambulance NHS Trust	GD
Roy Dexter	Elected Governor – Thanet	RD
Paul Durkin	Elected Governor – Swale	PD
Brian Glew	Elected Governor – Canterbury	BG
Carole George	Elected Governor – Dover	CG
Cllr Patrick Heath	Nominated Governor (Local Authorities)	PH
Alan Hewett	Elected Governor - Shepway	AH
June Howkins	Elected Governor – Shepway	JH
Vikki Hughes	Elected Staff Governor	VH
Reynagh Jarrett	Elected Governor – Thanet	RJ
Eunice Lyons-Backhouse	Elected Governor – Rest of England and Wales	ELB
Michael Lyons	Nominated Governor – Volunteers Working with the Trust	ML
Dee Mepstead	Elected Governor – Canterbury	DM
Liz Rath	Elected Governor – Dover	LR
Ken Rogers	Elected Governor – Swale	KR
John Sewell	Elected Governor – Shepway	JS
Philip Wells	Elected Governor – Canterbury	PW
Marcella Warburton	Elected Governor – Thanet	MWa
Martina White	Elected Governor – Dover	MW
Junetta Whorwell	Elected Governor - Ashford	

IN ATTENDANCE:

Mark Austin	Assistant Director of Finance (Minute No. 21/14)	MA
Jeff Buggle	Director of Finance and Performance Management	JB
Sue Cook	Consultant Nurse, Palliative Care (Minute No. 23/14)	SC
Alison Fox	Trust Secretary	AF
Peter Gilmour	Director of Communications	PG
Chris Green	Information Analyst (Minute No. 20/14)	CGr
Melanie Hill	Corporate Planning & Performance Lead (Minute No. 21/14)	MH
Fin Murray	Director of Estates & Facilities (Minute No. 22/14)	FM
Sally Smith	Dep. Chief Nurse & Dep. Dir. of Quality (Minute No. 24/14)	SS
Jonathan Spencer	Non Executive Director	JSp
Paul Stevens	Medical Director	PS
Steven Tucker	Non Executive Director	ST
Dee Boorman	Committee Secretary	DBo
Stephen Dobson	FT Membership Engagement Co-ordinator	SD

MINUTE NO.		ACTION
14/14	**CHAIRMAN'S EVALUATION** Due to the confidential nature of this item, which was led by Jonathan Spencer, it is recorded as a separate minute.	

MINUTE NO.		ACTION

15/14 **CHAIRMAN'S INTRODUCTIONS**

The Chairman welcomed the members to the meeting, and in particular the new Governors to their first full Council meeting (Carol George, Marcella Warburton, Martina White, Roy Dexter and Vikki Hughes).

16/14 **APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST**

Apologies were noted from:

Stuart Bain	Chief Executive
Peter Jeffries	Nominated Governor, University of Kent
Derek Light	Elected Governor - Ashford
Valerie Owen	Non Executive Director
Julie Pearce	Chief Nurse and Director if Quality & Operations
Peter Presland	Non Executive Director

There were no declarations of interest.

17/14 **MINUTES FROM THE LAST PUBLIC MEETING HELD ON 14 JANUARY 2014 AND MATTERS ARISING**

The minutes of the meeting held on 14 January 2014 were agreed as a correct record with the following exception:

LR recalled that both positive and negative patient stories would be provided but those for this meeting were all positive. SS explained that the most recent story, which was negative, had been tabled and would be presented during the meeting.

The Council of Governors noted the updates on the actions table and the following comments were made:

05/14 Performance Update

PS explained that Careflow (which was originally devised by 2 Surgeons) is being developed to provide the ability to send information to a range of technology (mobiles, I-phones etc). It would generate a series of alerts for the recipient to decide whether action was needed. It complied with data governance principles and information could be downloaded to form part of the patient record. The application is being used in a number of innovative ways by the Kent Kidney Research Group and a pilot was underway with a practice in Canterbury to link with diabetes nurses and this facility was being explored further.

08/14 CoG Strategic Committee

NW was aware that JC had queries relating to the involvement of the Royal College of Pathologists. The Divisional Director would be joining the meeting for the afternoon and NW suggested that JC liaise with her. NW had agreed to sit on the KPP Management Board to represent EKHUFT as an interim measure.

MINUTE NO.		ACTION
08/14	**CoG Nominations and Remuneration Committee** NW advised that a recent change by Monitor to the Code of Governance suggested that the Chair or independent Non Executive Director should chair the Nominations Committee. It was agreed that KR would continue to chair the Committee.	Agreed
10/14	**EKHUFT Maternity Services Update** LR noted the inference that the unexpected increase in births was the reason for the requirement for more Midwives. The Council had highlighted that the Midwife to birth ratio was 28.5:1; this was not the Gold Standard, and an increase was required even if there was no rise in the birth rate. JS believed that the establishment was correct but the number of Midwives on maternity leave was unusually high. SS agreed to clarify the position and advise the Council. JC asked for clarification of the statement in the annual plan: "review the births to Midwives ratio risk if the Commissioners withdraw current quality top-up funding." JB explained the Commissioners had queried the additional top-up they paid to achieve the Maternity birth ratio and they proposed to remove this from the contract for 2014/15.	SS
18/14	**COUNCIL OF GOVERNOR ELECTION RESULTS** The new Governors were invited to introduce themselves. Buddying arrangements would be discussed over lunch. John Sewell, David Bogard, Junetta Whorwell and Philip Wells were congratulated on their re-election.	
19/14	**PERFORMANCE UPDATE** JB presented the report and the following highlights were made. *Performance:* ▪ The Trust achieved the A&E 4 hour target in January. ▪ There were some pressure points for the 31 Days Diagnosis to First Treatment and the 62 Day cancer pathways. The 62 Day Screening Referral to Treatment was unlikely to be compliant for the whole of the Quarter. ▪ Harm free care remained above the national target. ▪ There were no MRSA bacteraemias in January and C.Difficile had returned to the previously very low levels, with 2 cases reported in January. ▪ The mortality rate in all specialties remained good ▪ An update was evident in the Friends & Family Test recorded scores and the Trust was slightly ahead of the national target. *Activity:* ▪ Generally, Primary Care Referrals were above plan ▪ Outpatient activity continued to be higher than the contract and for the same period last year. ▪ All types of admitted activity were broadly in line with plan although A&E attendance remained higher than planned by 4%.	

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Financial Performance:

- January ended with cumulative surplus of c.£6.1m, which was achieved through full use of the contingency
- There was still very high expenditure on staffing, but indications were that there would be a reduction in temporary staffing costs in February. This suggested that some of the actions that had been instigated were taking effect.
- The Trust remained behind on the Cost Improvement Plan – it would achieve the plan but not the stretch target.
- The forecast for the year end out-turn was achievement of a surplus of £3.7m (£1.7m below plan for this year) although this would only be possible by using the contingency.
- The key risk was the contract negotiations and the ability of Commissioners to afford the payment for the levels of activity being performed.

Council of Governors discussion (Performance Update):

ML asked about expenditure on agency staff for A&E and about progress on recruitment of overseas staff. JB explained that the budget for temporary staff was being exceeded by £8.5m, however the majority of this was on NHS Professionals staff for whom the Trust paid NHS rates rather than a premium rate.

DM asked if many A&E staff had left the organisation when the rotas were changed. SS advised that the A&E staff at QEQM had designed their own rotas according to the pattern of patients attending, and there had therefore been no resignations as a result. The overseas nurses were now in place supporting the NHSP staff and wards.

JS was interested in the effectiveness of any initiatives instigated to combat the increase in A&E attendance. JB explained that Trust was 4% above the contract level and in line with last year. PS added that the clinical care forums, comprised of a number of healthcare organisations, were beginning to work together on A&E attendances. It was hoped to duplicate an effective pilot in Redhill where the local hospital proactively sent staff into nursing homes frequently to address needs and this had caused a reduction in admissions by 3-4%.

AC noted that tracking frequency of attenders at A&E who had returned to nursing homes was easy but recording of perceived inappropriate attendance initially was more difficult. CGr replied that analysis of avoidable attendances in A&E a year ago had demonstrated that c.40% of patients could have been treated in Primary Care.

RJ asked whether there was any evidence regarding the age groups attending A&E; there appeared to be a culture of using A&E as the default rather than the GP practices. CGr confirmed that the age profiling showed that the majority of attenders were in the 20-30 yrs group.

LR asked if it was known how many people were not registered with a GP and whether they were in a particular age group and CGr confirmed that this was being investigated and the results would be relayed to the Governors. CGr

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	GD reported that SECamb had seen an increase in activity of 8% from last year and there was evidence that this activity was not converting to A&E attendances. He welcomed joint working with the Trust on avoidable admissions. AH highlighted the difficulties being experienced in the 62 day pathway. PS explained that the increase in activity may be due to TV soap themes. NW noted that the screening target could be affected by very small numbers but he was concerned about the 62 Day Referral to Treatment by GPs and an in-depth analysis was planned for the NED Governance Group, which would be reported to the Board. There also needed to be a mechanism in place for being aware of stories of health issues in TV programmes and public health campaigns so that the impact could be planned for.	Noted
	JC asked whether problems in one pathway could tip the balance to non compliance in the total 62 Days pathway. NW reassured her that this would be included in discussions at the March Board Meeting. PS advised that it was now possible for X-ray requests to be made electronically and the report sent back into the requester's email in-box. This speedy response should have a positive effect on the 62 Day waits.	Noted
	<u>Early Feedback from the CQC Visit</u> NW advised that the CQC had given positive verbal feedback on the Governors' session. PS summarised that the CQC had commended the front-line staff; they had all exhibited a high degree of care. He outlined the issues that had initially been raised by the CQC. The inspectors were critical of the Emergency Care Centre at KCH although ECIST were using it as a model of good practice for other Trusts. NW advised that the Trust had an opportunity to respond to matters of accuracy prior to the eventual publication of the CQC's report. The Governors would be kept up to date with progress.	Noted
	Council of Governors discussion (Early Feedback from the CQC): JC advised of the CQC's suggestion that Governor representation be invited to the summit meeting with all stakeholders and this was agreed.	AF
	JW asked if there was a problem with recruitment of Registrars; in one area although applications had been received, no appointments had been made. PS replied that safety and quality were paramount and appointments were made on that basis. One of the difficulties was the lack of people to carry out general medicine rather than to specialise in a particular area.	

MINUTE NO.		ACTION
	High Risk and Emergency Surgery Update PS explained that since the decision to centralise High Risk and Emergency Surgery at KCH, he had met the Surgeons to discuss a number of scenarios. Senior medical staff in other specialisms (Anaesthetists etc.) had identified a number of risks and had evaluated the impact on potential outcomes and it had been decided that the decision did not align with the Trust's aim of servicing the whole population of East Kent, and that if the centralisation of this surgery at KCH was not the safest option it would therefore not proceed in May as previously announced. Thirteen work streams had been set up and would proceed as planned. An update would be given at the March and April Board Meetings. **Council of Governors discussion (High Risk and Emergency Surgery):** BG was aware of the media and political interest but once the work on the interim solution had been completed, there would be a range of issues that would impact on the longer term strategy of the Trust and the Trust needed to focus on these. He sought assurance that the Trust had a coherent strategy for managing stakeholder relationships and was actively engaging with the various groups in the community to maintain a positive relationship. NW agreed with the importance of ensuring that the stakeholders understood the issues and plans. SB and NW had met all the MPs and the CCGs and every effort would be made to maintain positive relationships. JS believed that there was a perception in the Trust that recruitment to Consultant General Surgeon posts over the last 2 years could have been more vigorous and asked for reassurance that effort was being made to recruit to these posts, irrespective of the model to be adopted. PS advised that there were 2 Job Descriptions for posts which would meet both the Royal College of Surgeons and the Trust's requirements and that these were being put out to advert as soon as possible. RJ asked for an update on the Deanery's move of middle grade Doctor training from London to Brighton and the vision to train Doctors in-house. PS advised that links with Health Education Kent/Surrey/Sussex would take some time to re-forge but there was commitment to reinstate effective training rotations. **Council of Governors decision/agreed actions:**	Noted
	The reports and updates were noted.	Noted
20/14	**A&E CARE IN EKHUFT** CGr gave a presentation that covered analysis of: the ECIST Review; correlation, age variation, deprivation, Practice population and the recommendations. The definition of a small GP Practice was a single-handed Practice of c.2,000 patients. **Council of Governors discussion:** CGr clarified for JS that in the analysis, A&E referred to all the EKHUFT Emergency Departments; he did not have data for the Community sites.	

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	In response to LR, CGr confirmed that there was correlation between the ward deprivation profile and the GP population per practice and a 'league table' of Practices was being drawn up. He believed that the Trust should start to challenge them because the highest Practice based on deprivation and population was a single-handed one in the most deprived area. Additionally, the 20-30 years age group of patients expected immediate access to healthcare and any difficulties in obtaining GP appointments encouraged them to go directly to A&E. If this educational issue was not addressed now, the next generation would believe that A&E was the correct first port of call. GD suggested that a review of staffing profiles against the A&E attendance profile be included in the recommendations. For the 999 service the rosters were being changed to fit in line with the new profile (6:30 a.m. on Saturday mornings and 12 noon on Saturdays and Sundays, with a large spike in demand on Sundays). CGr confirmed that this analysis was underway. KR reported a need for improved communication because a large number of attenders at the KCH A&E were from Faversham and investigation had shown that people were largely unaware of the MIU at Faversham so many went to Estuary View which was well signed. JW asked if there were statistics for the number of babies and children attending A&E and CGr advised that it was possible to break down the data further. NW summarised that much of the analysis had arisen from conversations about key variables that influenced A&E performance. If it was possible to identify issues that correlated, the Trust would be able to determine pressure points in A&E and put in place an alert mechanism. There now needed to be a move from collating information into clear collaborative working to result in a more effective system. **Council of Governors agreed actions/decisions:** The report was noted with thanks.	Noted
21/14	**EKHUFT ANNUAL PLAN 2014/15-2015-17 UPDATE** MA gave a presentation that covered: Updates since the last CoG meeting A Corporate I&E overview Bridge of changes NHS -v - Non NHS Income in the 2014/15 Plan 2014/15 service developments Five year capital programme Financial risks. The difference in revenue from non patient services from other bodies (2013/14 - £14.1m and 2014/15 - £16.6m) was due to the re-charge from NHS England as funding for the new IT system.	

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	Re the service delivery slide, MA highlighted that £1.8m had been included in the Plan for this year for C.Difficile but it was expected that ward staffing investment would reduce that exposure by £500K so investment was needed to produce a reduction in the number of infections by 5 to make that improvement. **Council of Governors discussion:** RJ referred to the Trust's allocation of £2.5m for the Francis Report work and MA confirmed that this was a one-off amount and was included in the non-recurrent line. RJ noted that NHS income was expected to fall considerably over Plan from 2015-16 and asked whether this was due to less activity or a change in the tariff. MA confirmed that it was expected that the demand on the system would increase but payment received for activity would reduce. This pricing issue was of concern and was being addressed as part of the longer term strategy. DB asked if there was any progress on the proposal to charge private health insurance companies for NHS care. MA explained that this element was included in the I&E overview slide under 'other income' but the difficulty was the length of time (c. 18 months) it could take for the NHS to identify those people and re-claim the money. LR asked about the Social Care Village initiative and MA advised that this was the 'step down' beds that were purchased and was a planned temporary approach. RJ questioned the risk of Commissioners wishing to unpick local agreements. MA advised that the environment had changed slightly regarding fines, which was to the Trust's benefit. BG made two observations, regarding 1. the process and 2. Non NHS Income. 1. The process: There was a need for a structured process, which currently starts in October, to gain maximum advantage from MA's work. BG proposed that the CoG Strategic Committee consider this and bring a proposal back to the full Council. He suggested a much earlier start to the process, i.e. at the April or June CoG Strategic Meeting. JS agreed to build this in the committee's planning schedule.	JS
	2. Non NHS Income: BG appreciated MA's work to identify the various forms of income but sought clarity on the definition and how to apply the test that the Non NHS income generated activity in no way impacted on the Trust or its purpose. The presentation had demonstrated that there had been no impact over the past year in the areas shown and there was therefore no cause for concern this year. NW reiterated the Governors' role to be assured there would be no negative impact, however, Governors had been unable to collectively define the evidence that they would wish to see in order to be assured that there would be no negative impact. He suggested that the CoG Strategic Committee also include this in their discussions.	JS

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	AF suggested that with effect from 1 April 2014, when considering any new projects with an element of Non NHS income, a clear outcome could be built into the business planning and approval process so that Governors could affirm they had challenged and the Board had specifically considered it.	Noted
	JB advised that the areas shown on the table were based on the definition of Non NHS Income as given by Monitor for use for the annual accounts. There may be elements that the Council wished to exclude or include. JSp encouraged colleagues to review the table showing the planned service developments; these were the Executive Team's set of proposals that were affordable.	
	JC raised concerns about the KPP development. ▪ Page 19 mentioned the expectation of zero change in activity for direct access work; this contradicted the full business case which stated there will be an increase in direct access work. ▪ Page 40 stated that it was envisaged that £25m of savings will be made. Was this based on the assumption of an increase or decrease in work? ▪ It was vital to have efficient IT systems in place. ▪ JC believed that Pathology should have its own transportation system. ▪ On page 33, what was meant by 'further centralisation of pathology services outside KPP'?	
	JB explained that the Finance team had been prudent in relation to KPP, based on the knowledge of growth in previous years. MA added that the KPP would not generate more activity but would deliver the same, therefore showing zero growth, He agreed to clarify this in the Plan.	MA
	In terms of the transport and IT, JB agreed about their importance and they were detailed in the KPP business case. The transport element referred to finding the most effective way to provide a service for transporting samples across the patch and was fundamental to developing the KPP towards a much larger client and income base.	
	Council of Governors agreed actions/decisions:	
	JC agreed to discuss her concerns re the KPP with the Divisional Director of Clinical Support Services.	JC
	AC welcomed a more detailed breakdown about education and training revenue.	MA
	JS asked about the process and timetable going forward. MA explained that feedback would be appreciated this week. It was agreed that any further comments on the Plan be relayed to JS or MA on the plan this week.	All
	The CoG Strategic Committee would incorporate into their work schedule earlier consideration of the Plan.	JS

MINUTE NO.		ACTION
	The Governors confirmed acceptance in principle that the propositions in the slides on non NHS income would not be detrimental to NHS activity.	Agreed
22/14	**PATIENT TRANSPORT**	
	FM gave a presentation on non emergency patient transport. By mid February CCGs were confident that NSL would be achieving the KPIs that were in the contract. However, there was belief that the procurement process was flawed in that NSL had anticipated there would be longer journeys, whilst in reality all the journeys were lots of shorter journeys, either discharges to people's homes or to transport patients between sites. It had therefore been agreed to extend the date for improvement to May. **Council of Governors discussion:** RJ asked if there was any evidence that NSL would walk away from the contract in May and if so whether a contingency plan had been identified. FM replied that this had been discussed with the West Kent CCG Accountable Officer and there was a risk. However, NSL's investors were disappointed in the transport element's performance and were keen to improve it. Improvements had been seen in other areas of the country. Contingency plans were being worked up in case they were needed. **Council of Governors agreed actions/decisions:** The update was received with thanks.	Noted
23/14	**END OF LIFE CARE**	
	SC gave a presentation on palliative care. **Council of Governors discussion:** DM added that 'In Your Shoes' and 'In Our Shoes' sessions were planned for each of the 3 main sites. Relatives would be invited and this would provide an opportunity for all areas of healthcare professionals to discuss their experiences with them. JS was aware that the End of Life Board dealt with CPR decisions and asked if there was a separate forum for people on the end of life conversations pathway. SC advised that the DNR CPR advice would be documented in the patient's notes. JW asked whether religious wishes were included, about pain management, and about liaison with siblings in cases involving children. SC advised that religious wishes were catered for and included on the documentation, the conversations regarding the method of pain management were documented, and usually patients with young children were referred to the hospice for bereavement care.	

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	AC stated that some pathways, including this, involved very difficult conversations and the focus needed to be on patient care rather than achieving targets. Although he had found the Liverpool Care Pathway unwieldy he found it difficult to understand that one of the reasons for its cessation was lack of evidence base, as much of medicine was based on judgement. He welcomed a realistic view of the type of evidence that was sought in the future. SC agreed that communication and documentation were the most important elements in any pathway.	
	Council of Governors agreed actions:	
	The presentation was received with thanks.	Noted
24/14	**COUNCIL OF GOVERNOR COMMITTEES**	
	Communication & Membership Committee	
	BG explained that the purpose of the Committee was to engage as Governors and facilitate engagement with the Membership and the public. It also contributed to the Trust's activity in recruiting new members.	
	The report summarised several themes that had been agreed regarding membership engagement events. BG encouraged Governors to support the final Outpatients Consultation Events on 13th March. Support was needed for all engagement events in order to make them viable.	
	There had been a modest increase in Trust Membership in March since February and the membership remained at c.11,000. There were some very good initiatives being worked up over the next few months, with presentations to different groups in East Kent and a recruitment opportunity afterwards.	
	BG thanked the contributors for their articles for the February edition and requested articles for the July publication by 2 June.	
	As detailed in the report, there is a prospect in the future of an expanded area for Governors on the Trust's website to offer more interactive engagement with Trust members. However, this would require commitment by the Council and BG asked if they wished to progress this.	
	Council of Governors discussion (Comm. & Membership Committee):	
	NW added his thanks to those who had submitted articles for the newsletter, which were excellent. He asked for Governors' views re the website development and the Governors agreed that it would be easier to commit to it if it could be done at home rather than having to travel to one of the Trust's sites.	
	BG confirmed that home working may be possible over time, but not initially. A vote was taken; generally the Council agreed in principle with proceeding.	Noted

MINUTE NO.		ACTION
	PD had received a request for Health Watch to attend a 'Meet the Governor' event but this was not thought to be a good idea as the aim was for people to meet the *Trust's* Governors and this could cause confusion. RJ mentioned the importance of visibility when attending these events to maximise their effectiveness.	Noted
	Patient & Staff Experience Committee	
	JC reported that a brainstorming meeting was planned for 12 March at 10 a.m. in the Chapel at KCH to discuss the Committee Chair and the work plan for the year. New Governors were very welcome to attend. The Standards Monitoring Group, on which JC was the Governor representative, was re-forming as a result of changes to NHSLA to look at outcomes rather than compliance with fixed standards. SS was checking whether a Governor representative was still required.	SS
	Patient Story	
	SS outlined the patient story which related to the top complaint themes about attitude and communication. The Matron in Outpatients had visited the patient at home and he had provided some constructive feedback and had been invited to discuss his experience at an appropriate forum. Relevant staff were attending courses on managing conflict and the staff involved in this case were receiving further training.	
	NW asked about the mechanism for disseminating learning from patient stories. SS explained that concerns that related to a specific team would be taken up with them, but agreed to give thought to how to handle more general complaints.	SS
	CG commented that administrative staff may not have been recruited with a view to caring for patients and suggested that this be highlighted during their induction or training.	
	LR expressed concern that a 10 minute slot was allocated to each patient. AC agreed that clinics often ran late and there was a tension between quantity and quality although the latter was of most importance.	
	Strategic Committee	
	JS reported on the meeting held on 14 February. Discussion had focused on the Outpatients Consultation which was an agenda item in Part II of the meeting.	
	Nominations and Remuneration Committee	
	KR reported on a review of the remuneration for NEDs. The current remuneration levels of the Chairman and NEDs were comparable with other Trusts in the UK and it was agreed that they remain unchanged so there would be no increase in remuneration awarded for 2014/15.	Noted

MINUTE NO.		ACTION
	Discussion had also taken place as it was proposed that the mileage allowances for Chairs and Non-Executive Directors of Non-Foundation Trusts would increase from 53p per mile to the same rate as that received by AfC staff, being 67p per mile. The Nominations and Remuneration Committee recommended that this increase be applied in EKHUFT. However, NW had asked the Director of HR for guidance as NEDs were not employees of the Trust and it was agreed that the decision should be held until his advice was received. It was noted that the mileage rate had to be reflective of fuel consumption and only a proportion of fair wear & tear to the vehicle, and could also be subject to tax and national insurance and had to be declared.	Decision deferred
	KR presented the terms of reference for the committee, following Monitor's most recent guidance. These were agreed. KR mentioned that his term as Chair of the Committee would end later in the year and welcomed new Governors to the Committee.	Agreed
	Audit Working Group	
	RJ reported that the next meeting would be held in July, and welcomed new members as this was a small group with a risk of being non quorate in meetings. He would be stepping down as the lead Governors on this group in July 2014.	Noted
25/14	**REVIEW OF THE COUNCIL OF GOVERNOR COMMITTEE MEMBERSHIP**	
	NW invited the members, in particular the new Governors, to give consideration to joining any of these committees and advise Sarah Swindell or Dee Boorman.	All
26/14	**FEEDBACK FROM GOVERNORS WHO ATTEND WIDER TRUST GROUPS**	
	DM reported that she had joined a group to focus on implementation of the Francis Report. NW added that 5 themes had been identified for discussion by the Board Members and members of staff. The topic for the March Board Meeting was 'Junior Doctors and Matrons as Guardians of Safety' and April's Board would focus on culture. With the aim of involving staff in Board discussions, it was hoped to identify staff across all sites who would be interested in taking part and in which areas.	
	AC reported that he was a member of the Research & Development Committee. This was a large area of activity in the Trust and it was agreed that an annual update would be given to the Council of Governors. It was also agreed that an annual report be given by the Director of Medical Education to understand this area more fully.	Work Planner
27/14	**FEEDBACK FROM THE BOARD OF GOVERNORS SELF EVALUATION**	
	NW reported that after discussions with the Board, he had identified 4 themes to be developed: 1. Continued engagement with a wide range of different stakeholder, especially building relationships with the local health economy.	

MINUTE NO.		ACTION
	2. Cost Improvement Programme and quality. A more robust process was required to understand the process of the quality assurance.	
	3. Board assurance: a clearer understanding was needed of how assurance was built from the bottom up.	
	4. Board of Director skills: a meeting of the Nominations Committee was planned to look at skills of the Executive Directors. A meeting of the CoG Nominations Committee was also planned to consider the skills of the NEDs.	Noted
28/14	**QUESTIONS FROM MEMBERS OF THE PUBLIC AND ANY OTHER BUSINESS**	
	There were no members of the public present and no other issues were raised.	
29/14	**DATES OF FUTURE MEETINGS**	
	The next full Council of Governors Meeting was scheduled for Friday 9 May 2014 at the Julie Rose Stadium.	Noted