

Council of Governors Public Meeting

Thu 20 May 2021, 09:30 - 12:00

via teleconference WebEx



East Kent
Hospitals University
NHS Foundation Trust

Agenda

09:30 - 09:35
5 min

21/1. Chair's introductions

To note *Niall Dickson, Trust Chairman*

Agenda Public.pdf (2 pages)

09:35 - 09:35
0 min

21/2. Apologies for Absence and Declarations of Interest

To note *Niall Dickson, Trust Chairman*

09:35 - 09:35
0 min

21/3. Minutes from the last Council of Governors' Public meeting held on 9 March 2021 and matters arising

To agree *Niall Dickson, Trust Chairman*

03 unconfirmed minutes.pdf (7 pages)

09:35 - 09:35
0 min

21/4. Outstanding actions

To note *Niall Dickson, Trust Chairman*

04 Action Log.pdf (1 pages)

09:35 - 09:40
5 min

21/5. Ratification of Virtual Votes since the last meeting

To note *Niall Dickson, Trust Chairman*

05 Virtual voting.pdf (2 pages)

09:40 - 09:40
0 min

21/6. Annual presentation of the Register of Interests and Fit and Proper Person declaration

To note *Alison Fox, Group Company Secretary*

09:40 - 09:45 **21/7.**

5 min

Update on timetable for Annual Documents:

To note *Alison Fox, Group Company Secretary*

- Annual Report
- Annual Accounts
- Quality Report
- Self-certification against provider licence

07 Annual Documents.pdf (2 pages)

07 Annual Documents Appendix 1.pdf (12 pages)

09:45 - 10:15 **21/8.**

30 min

Chair's report

To discuss *Niall Dickson, Trust Chairman*

NOTE: will include discussion paper on how Council wishes to work moving forward - workplan and meeting schedule

08 Chairman's Report.pdf (7 pages)

08 Appendix 2 MEC ToR.pdf (1 pages)

08 Appendix 3 NRC ToR.pdf (2 pages)

08 Appendix 4 Proposed SPEC ToR.pdf (2 pages)

08 Appendix 5 Proposed AGC ToR.pdf (2 pages)

08 Appendix 6 Annual meeting schedule & workplanner.pdf (1 pages)

10:15 - 10:30 **21/9.**

15 min

Chief Executive's Report

To discuss *Susan Acott, Chief Executive Officer*

Verbal

10:30 - 11:00 **21/10.**

30 min

Introduction to new NEDs and Overview Report

To discuss *Debra Towse, Chair NRC*

NOTE: IPR, Risk Register and Finance Report will be attached to this item.

10 Finance briefing.pdf (15 pages)

10 IPR.pdf (23 pages)

11:00 - 11:15 **BREAK 11:00-11:15**

15 min

11:15 - 11:30 **21/11.**

15 min

Constitution Review Group Report

To agree *Member of Constitution Review Group*

- 11 Constitution and Policy Review Group.pdf (2 pages)
- 11 Appendix 1 Discussion & Recommendations.pdf (7 pages)
- 11 Appendix 2 List of policies and guidance.pdf (1 pages)
- 11 Appendix 3 NHS Providers Guidance.pdf (2 pages)

11:30 - 11:35
5 min

21/12.

Lead and Deputy Lead Governor Elections

To agree *Alison Fox, Group Company Secretary*

- 12 LG & DLG election.pdf (2 pages)
- 12 Appendix 1 Lead Governor Role Description.pdf (2 pages)
- 12 Appendix 2 Deputy Lead Governor Role Description.pdf (2 pages)

11:35 - 11:40
5 min

21/13.

Committee Membership

To agree *Alison Fox, Group Company Secretary*

- 13 Committee membership.pdf (3 pages)

11:40 - 11:50
10 min

21/14.

Governor feedback on events attended

11:50 - 11:55
5 min

21/15.

Questions from the Public

Niall Dickson, Trust Chairman

11:55 - 12:00
5 min

21/16.

Any Other Business

Niall Dickson, Trust Chairman

12:00 - 12:00
0 min

21/17.

DATE OF NEXT PUBLIC MEETING - To be confirmed

12:00 - 12:00
0 min

RESOLUTION TO MOVE INTO PRIVATE SESSION

That pursuant to the Trust's Constitution the Council of Governors is moving into closed session. All members of the public, including press, are to be excluded due to the confidential nature of the business to be discussed concerning contracts, negotiations and staff.

COUNCIL OF GOVERNORS MEETING IN PUBLIC
20 MAY 2021, 9.30am
Virtual meeting – joining details in calendar invite

This meeting will be preceded by an informal meeting of the Council, starting at 9.00am

The meeting will be conducted in line with the Trust Values below:

AGENDA

Reference Conf. 21/

Paper 21/

OPENING MATTERS				
01.	Chair's introductions	To note	9.30 (05)	<i>Niall Dickson Trust Chairman</i>
02.	Apologies for Absence and Declarations of Interest	To note		<i>Niall Dickson Trust Chairman</i>
03.	Minutes from the last Council of Governors' Closed meeting held on 9 March 2021 and matters arising	To agree /03		<i>Niall Dickson Trust Chairman</i>
04.	Outstanding actions	To agree /04		<i>Niall Dickson Trust Chairman</i>
05.	Ratification of Virtual Votes since the last meeting	To note /05	9.35 (05)	<i>Niall Dickson Trust Chairman</i>
06.	Annual presentation of the Register of Interests and Fit and Proper Person declaration	To note /06		<i>Alison Fox Group Company Secretary</i>
07.	Update on timetable for Annual documents: <ul style="list-style-type: none"> • Annual report • Annual accounts • Quality Report • Self certification against provider licence 	To note /07	9.40 (05)	<i>Alison Fox Group Company Secretary</i>



08.	Chair's report	To discuss /08	9.45 (30)	<i>Niall Dickson Trust Chairman</i>
<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="background-color: #800040; color: white; padding: 5px 15px; border-radius: 10px;">Our patients</div> <div style="background-color: #660066; color: white; padding: 5px 15px; border-radius: 10px;">Our people</div> <div style="background-color: #008080; color: white; padding: 5px 15px; border-radius: 10px;">Our quality and safety</div> </div>				
09.	Chief Executive Officer's report	To discuss	10.15 (15)	<i>Susan Acott Chief Executive Officer</i>
10.	Introduction to new NEDs and Overview report	To discuss 10a IPR 10b Risk register 10c Finance summary	10.30 (30)	<i>Chair, CoG NRC To introduce</i>
BREAK 11.00 – 11.15				
11.	Constitution Review Group report	To agree /11	11.15 (15)	<i>Chair, Constitution Review Group</i>
<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="background-color: #FFA500; color: white; padding: 5px 15px; border-radius: 10px;">Our future</div> <div style="background-color: #0056B3; color: white; padding: 5px 15px; border-radius: 10px;">Our sustainability</div> </div>				
12.	Lead and Deputy Lead Governor elections	To agree /12	11.30 (05)	<i>Alison Fox Group Company Secretary</i>
13.	Committee membership	To agree /13	11.35 (05)	<i>Alison Fox Group Company Secretary</i>
14.	Governor feedback on events attended		11.40 (10)	
CLOSING MATTERS				
15.	Questions from the public		11.50 (05)	<i>Niall Dickson Trust Chairman</i>
16.	Any other business		11.55 (05)	<i>Niall Dickson Trust Chairman</i>
17.	Date of next meeting TBC		12.00 Meeting ends	<i>Niall Dickson Trust Chairman</i>

RESOLUTION TO MOVE INTO PRIVATE SESSION

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**UNCONFIRMED MINUTES OF THE COUNCIL OF GOVERNORS MEETING
TUESDAY 9 MARCH 2021 AT 09.30****PRESENT:**

Jane Ollis	Acting Trust Chair (Chairman)	Chair
Bob Bayford	Partnership Governor – Local Authorities	BBa
Ross Britton	Elected Governor – Swale	RBr
John Fletcher	Elected Governor – Ashford	JFI
	From item 63	
Nick Hulme	Elected Governor – Ashford	NHu
Linda Judd	Partnership Governor – Volunteers	LJu
Alex Lister	Elected Governor – Canterbury	ALi
Bernie Mayall	Elected Governor – Dover	BMa
Chris Pink	Elected Governor – Rest of England	CPi
Carl Plummer	Elected Governor - Folkestone & Hythe	CPI
Alex Ricketts	Elected Governor – Canterbury	ARi
Ken Rogers	Elected Governor – Swale	KRo
Paul Schofield	Elected Governor – Thanet	PSc
Debra Towse	Partnership Governor – Universities	DTo
Marcela Warburton	Elected Governor – Thanet	MWa

IN ATTENDANCE:

Susan Acott	Chief Executive Officer	CEO
Julie Dawes	Interim Group Company Secretary	JD
Alison Fox	Acting Director of Governance	AF
Fiona Wise	Improvement Director, NHSE/I	FW
Amanda Bedford	Committee Secretary (minutes)	AB

MINUTE NO. CoG/20/		ACTION
54.	<p>CHAIRMAN'S INTRODUCTIONS</p> <p>The Chair welcomed members to the meeting and noted that she was chairing in her role as the Acting Trust Chair following the departure of Stephen Smith, who had completed his three years of office. The new Trust Chair, Niall Dickson, would join the Trust on 5 April.</p> <p>The Chair said that, sadly, her first duty today was to report the death of Jenny Chittenden – Public Governor for Swale. Jenny had been elected in 2018 and had intended to stand again in the elections this year. She had been very active in her local community over many decades. The Council's condolences and sympathies went to the family.</p> <p>KR recalled Jenny's dedication to service and said that plans were being made for a commemoration to be given to the Trust as a reminder for staff and patients of her contribution.</p> <p>The Council observed a minute's silence to remember Jenny and reflect.</p> <p>The Chair noted her thanks to outgoing staff governors, Julie Pain and Carla Wearing, and Jane Martin – public governor for Ashford. Their commitment to the role and the experience and knowledge they brought to Council had been much appreciated.</p>	

Chair's initials

	<p>The Chair welcomed the new governors on Council: Ross Britton – Swale; John Fletcher – Ashford; Linda Judd – partner, Volunteers; Alex Ricketts – Canterbury, and Chris Pink – Rest of England & Wales. KR noted that this was the second term for John Fletcher, who had been a governor on the first Council.</p> <p>The Chair thanked the governors for their contributions the informal session preceding this meeting. Noting there had been discussions around working more efficiently together with the Trust and the priority for governors to be able to return on site and meet with patients and staff. She noted that the Chief Executive would be joining the meeting shortly to provide Council with an update on the current situation.</p> <p>AB reminded Governors that Council meetings were recorded to assist in writing up the minutes; the record was deleted after the draft minutes were agreed.</p>	
55.	<p>APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST</p> <p>Apologies were received from Liz Baxter and Sally Wilson. John Fletcher had advised that he may be joining the meeting late due to a sudden unavoidable diary clash. BM apologised in advance; she may need to step out of the meeting for a short period to take some critical calls.</p> <p>There were no declarations of interest.</p> <p>The Chair advised that she had invited AF to attend the meeting; although she was currently Acting Director of Governance AF's background knowledge of the issues that would be discussed would be helpful. The meeting agreed. Fiona Wise was present as an observer at the meeting in her capacity as NHSE/I Improvement Director.</p>	
56.	<p>MINUTES FROM THE LAST COUNCIL OF GOVERNORS' MEETING HELD ON 11 DECEMBER 2020 AND MATTERS ARISING</p> <p>The minutes of the previous meeting held on 11 December 2020 were accepted as a true and accurate representation of the meeting, with the exception of the mis-spelling of Debra Towse's name. There were no matters arising.</p>	
57.	<p>OUTSTANDING ACTIONS</p> <p>The updates on the outstanding actions were noted and the proposed closures agreed for items 11 – 15.</p> <p>Item 10: updated figures for waiting times in Orthopaedics would be provided after the meeting. To close when information is provided.</p> <p>Item 16: the update was noted. AB advised that a date would be set for the Director of Finance to present the new format of the Independent Performance Review (IPR) to the Council once it had been agreed. AF commented that the new formats would be aligned to the We Care priorities and the new format of the Risk Register would also be presented to Council. In the meantime the existing formats were still being presented to Board.</p> <p>ACTION: set a date to present the new format of the IPR and Risk Register to Council.</p>	AB

Chair's initials

	<p>AL commented that the agreement had been that the IPR and Risk Register would be presented at each Council meeting in public. While he understood that the formats were to be changed, this could be interpreted as a delay tactic and not conducive to demonstrating a spirit of openness. The Chair confirmed that the papers were part of the Board pack for the meeting that week, and accessible to Governors. She agreed that the papers could have been attached to the Council papers and confirmed that this would be the case moving forward.</p> <p>ACTION: Ensure that the IPR and Risk Register are presented to every Council meeting in public.</p>	AB
58.	<p>RATIFICATION OF ANY VIRTUAL DECISIONS TAKEN BY THE COUNCIL OF GOVERNORS SINCE THE LAST MEETING</p> <p>The paper was noted and the outcomes of the virtual votes RATIFIED. There were no comments.</p> <p>The Chair noted that the vote on the draft Council letter relating to funding had been carried, with one no vote. KR said that the letter had been drafted with support from the Director of Communications and it had been felt that including governors names would carry more weight. ALi and NHU questioned why the letter had not been sent given that the vote had passed.</p> <p>There was some discussion about the next step given that there were now five new governors on Council. The outcome was a vote to approve the letter by the Council, which was carried 12 for, one against.</p> <p>ACTION: Letter to be sent to Anne Eden without further delay.</p>	AB
59.	<p>REPORT ON THE ELECTIONS</p> <p>AB presented the report which summarised the outcome of the 2021 elections and updated on progress with the Staff and Dover constituency elections.</p> <p>AL commented that there was only reference to one Canterbury election in the report; AB said that she would check and subsequently circulated the relevant paragraph confirming both AL and AR's appointment in the election. [Note: AR was appointed to the vacancy created when Graeme Sergeant resigned, giving an end of term of office of 28 February 2024.]</p>	
60.	<p>CHAIR'S REPORT</p> <p>The Chair thanked the CoG Nominations and Remuneration Committee for their work in the recruitment of the new Trust Chair, Niall Dickson, and Non-Executive Directors Olu Olasode, who would take the Chair of the Integrated Audit and Governance Committee when Barry Wilding left in May, Luisa Fulchi and Martin Jolly. The NEDs would join the Trust on 1 April and the Chair on 5 April.</p>	
61.	<p>CHIEF EXECUTIVE OFFICER'S REPORT</p> <p>The CEO thanked the Governors for their work in appointing the Trust Chair and new NEDs. She looked forward to Niall Dickson joining the Trust and the influence and support that he would bring to the organisation.</p> <p>The CEO provided updates on the following issues.</p>	

Chair's initials

Pandemic: there were now less than 100 covid positive in-patients; in the height of the pandemic that number had exceeded 500. The second wave of the pandemic seemed to be receding with few patients being admitted and fewer deaths. However, the Intensive Care Units were still busy; covid patients tended to remain longer in ITU and the Trust was providing mutual aid to other regions up to a few weeks ago. There was emerging evidence that patients who had been very ill with the virus developed longer term cardiac and respiratory problems. This would have an impact on the demand in those services moving forward.

Maintaining the supply of oxygen over the three Trust sites had been a logistical challenge. Technical changes had been made on the William Harvey site to improve flow and work would start shortly to add an additional storage tank to improve resilience.

Moving forward, plans were underway to re-start all elective work in the next two weeks. Most of the urgent work had been delivered through the lockdown using the Kent and Canterbury site and the private sector. However, patients with complex needs who needed elective in-patient procedures had been impacted if their condition was such that they would need critical care following the operation. Some patients had chosen to decline the procedure date offered preferring to remain in shielding.

Critical Care: the CEO advised that there had been a visit by Kevin Fong, National Director of Critical Care, to see how the Trust had responded to the increase in critical care demand. The expansion at the William Harvey Hospital was of particular interest to him and the response to the emergence of the Kent covid variant. The National Chief Nurse had also visited and the feedback had been positive.

CQC visits: the CEO reported that there had been two visits from the CQC in the past week. One was a focussed visit on infection control as part of work being done with around 20 trusts nationally, looking particularly at the covid response. The feedback was positive to the degree that the Trust has been advised to apply for a lifting of the Section 31 notice applied in September.

The other visit was an unannounced visit to the Emergency Department. The full feedback had not been received yet, however, some areas of immediate concern had been raised by the visit team and action had already been taken in response. One of greatest concern was to make adaptations to the area created as a non-covid designated space for patients with a mental health crisis.

Appointments: A new Chief Nursing Officer would be starting in the Trust in June. An appointment had been made to the new role of Director of Governance. A substantive appointment had been made to the Director of Infection Prevention and Control: Neil Wigglesworth would start in the role the following week and he was eager to establish links with Christchurch University.

Vaccination programme: the CEO reported that 25,500 people had been vaccinated by the Trust and 90% of staff had received their first vaccination.

The CEO invited questions:

Chair's initials

AL asked whether there was anything further that the Council should be aware of following the CQC visit to the Emergency Department. The CEO said that the other verbal feedback provided at the time was concern about the senior medical staffing at Margate – an area which was difficult to recruit to. The Trust would be providing information to the CQC about the plans for recruiting to this area and also how any risks were mitigated in the meantime, primarily by QEQM shifts being covered by WHH consultants or locums.

They were also concerned that the creation of covid and non-covid areas in the department had meant the loss of the rapid assessment areas and that this may have added to the time taken to make an initial assessment of the patient's condition. The Trust would provide details of the actions and mitigations taken in relation to this.

There was concern that observation protocols were not being fully met after the initial assessment and that this was not helped by the multiplicity of IT systems and the delay with the planned work to ensure that they were integrated. In response there were plans to bring this work forward.

There was also a request to improve signage on doors at the WHH.

The CQC had also suggested that more patients could be triaged to the Urgent Treatment centre.

The draft reports on the two visits would probably be received in a couple of months after it had gone through the internal CQC quality checks. The CEO had written to the CQC outlining the immediate actions taken and this would be followed with another letter outlining the actions and mitigations taken in relation to the areas of concern.

KR noted that the recruitment problems in East Kent were long standing and he wondered whether the CQC recognised this and the need for investment in the area. The CEO confirmed that the Trust would provide context on the challenges created by the geography of the area. On a more positive note, there was some evidence that the pandemic had made people re-consider their lifestyle choices and senior vacancies at QEQM were now more attractive for professionals who wanted to move into a rural setting. A recent vacancy for a Consultant in Palliative Care, a specialty which was historically very difficult to recruit to, had actually resulted in the appointment of two candidates. Both were mid-career consultants who wanted to move away from London.

Strategic issues: The CEO commented that the pandemic had cemented strong relationships across the Kent and Medway area which has enhanced the development of the Integrated Care Partnership and the move to more collaborative working. The White Paper on health services has heralded that accountability structures will be put in place to support that development.

The Budget details relating to funding for the NHS had been disappointing given the amount of work that was needed to reduce the waiting lists that had built up and also to manage the emerging cohort of patients with long covid symptoms.

KR commented on the importance of communicating with the public to

Chair's initials

	<p>ensure they had confidence in their health services and would come to the hospitals for the care they needed. The CEO agreed and said that this needed to be a nuanced approach to target the relevant information for each type of patient. She noted that there had been fewer patient cancellations of treatment in the second wave.</p>	
62.	<p>CHAIR REPORT FROM AUDIT AND GOVERNANCE COMMITTEE: NO MEETING SINCE LAST COUNCIL MEETING – NO ISSUES TO REPORT</p> <p>It was noted that there had not been a meeting since the last Council meeting.</p>	
63.	<p>CHAIR REPORT FROM MEMBERSHIP ENGAGEMENT AND COMMUNICATIONS COMMITTEE: NO MEETING SINCE LAST COUNCIL MEETING – NO ISSUES TO REPORT</p> <p>It was noted that there had not been a meeting since the last Council meeting. As Jenny Chittenden had become the Committee Chair when AL took the Lead Governor role, the position would now revert to AL until the Committee membership was reviewed. AB noted that at the December Council meeting it had been agreed that the Lead Governor and Deputy Lead Governor could also take on the Chair of one Council Committee.</p> <p>AL said that there were actions from the previous meeting to be taken forward. He noted that the statistics relating to the last Governors newsletter had shown that it had only been opened by around 300 people. This suggested that the Council's engagement strategy would need to be re-drawn.</p>	
64.	<p>COUNCIL WORKPLAN 2021/22</p> <p>AB explained that the paper provided proposals for a workplan and meeting schedule for the first 3 months of the year; given that there were a number of new governors and a new Trust Chair, Council may wish to make changes to their ways of working in the longer term.</p> <p>The following decisions were made with respect to the recommendations in the paper.</p> <p>Timeframe for the work of the Constitution and Council Policy Review Group</p> <p>There were no comments made and the recommendation was AGREED unanimously.</p> <p>Extension of the term of office for the current Lead Governor to no later than 11 June</p> <p>There were no comments made and the recommendation was AGREED unanimously.</p> <p>To hold the election for Deputy Lead Governor within the same timeframe as the Lead Governor elections, noting that the position will therefore be vacant for up to 3 months.</p> <p>AL acknowledged that he had discussed this proposal with AB prior to the paper being issued, however, he had reflected and now proposed that there should be an interim appointment to the role. There was some discussion on whether a nomination could be made at the meeting and the appointment made immediately to avoid delay. DT commented that there were governors</p>	

Chair's initials

	<p>not present at the meeting and she felt that the existing process should be followed. She asked that steps were taken to make sure new governors who did not yet have nhs.net accounts were included in the process.</p> <p>It was AGREED that the normal election process would be followed and run without delay. It would be run against the existing Lead Governor role description and for the same time scale as the extension to the Lead Governor position.</p> <p>ACTION: run an election process for appointing a Deputy Lead Governor until the newly scheduled election process in May and ensure that new governors without nhs.net accounts were included.</p> <p>Pproposed meetings schedule for April to June 2021</p> <p>There were no comments made and the recommendation was AGREED unanimously. AB agreed to issue the meeting invitations that afternoon.</p> <p>ACTION: arrange and issue meeting invitations to Council and attendees.</p> <p>KR commented that in relation to the Council's role in appraising Non-Executive Directors the current arrangements for access to public Board meetings were not sufficient. The Chair agreed to look at this so that Governors were able to attend the webex via video rather than, as currently via a phone call.</p> <p>ACTION: arrange for Governors to be able to attend Public Board meetings via video link rather than on the phone.</p>	<p>AB</p> <p>AB</p> <p>AB</p>
65.	<p>QUESTIONS FROM THE PUBLIC</p> <p>There were no members of the public present.</p>	
66.	<p>ANY OTHER BUSINESS</p> <p>There was no further business.</p>	
67.	<p>DATE OF NEXT PUBLIC MEETING</p> <p>The next meeting of the Council was set for 24 May, with a training session scheduled for 27 April.</p>	

Signed _____

Date _____

Chair's initials

CoG 21/04 EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST - OUTSTANDING ACTIONS, COUNCIL OF GOVERNORS, PUBLIC							
Action No.	Date of Meeting	Min No.	Item	Action	Target date	Action owner	Progress Note (to include the date of the meeting the action was closed)
10	17.09.20	36		To provide Trust average waiting time for elective orthopaedics and share with the Council of Governors.		AB	11.12.20: AF explained that it was difficult to provide an average figure as each individual case needed to be judged on its own merits. Meeting agreed that the median figure would be more informative. AF agreed to provide this. 09.03.21: figures to be circulated after the meeting. Action can then be closed. 20.05.21: information circulated to governors on 17 March. Action closed.
16	11.12.20	48 Annex A	Resolutions	IPR, Quality Council themes & trend quarterly report and Risk Register to be taken to every Council meeting, closed session. Reference 10 09.03.21: a) set a date for the new format to be presented. b) IPR and risk register to be presented at every Council meeting in public. Minute number 57.		AB	09.03.21: IPR and Risk register being revised to mirror We Care programme, new versions expected to be used in April Board. Phil Cave, DoF, will present to Council. Theme & trend data quarterly so not available for this meeting. 20.05.21: presentation given on 19 April. Reports on workplan to be presented at all meetings, on agenda for this meeting. Propose close action.
17	09.03.21	58	Virtual vote ratification	Letter to be sent to Anne Eden without further delay.	Immediate	AB	20.05.21: letter sent on 16 March 2021 Propose close action
18	09.03.21	64	Council workplan	Run an election process for appointing a Deputy Lead Governor until the newly scheduled election process in May and ensure that new governors without nhs.net accounts are included		AB	20.05.21: process run and Ken Rogers elected. Propose close action
19	09.03.21	64	Council workplan	Arrange and issue meeting invitations to Council and attendees.		AB	20.05.21: meetings arranged. Propose close action
20	09.03.21	64	Council workplan	Arrange for Governors to be able to attend Public Board meetings via video link rather than on the phone.		AB	20.05.21: governors' access to public Board meetings is now via webex video link. Propose close action

REPORT TO:	COUNCIL OF GOVERNORS
DATE:	20 MAY 2021
REPORT TITLE:	RATIFICATION OF VIRTUAL VOTING SINCE LAST MEETING
SPONSOR:	
PAPER AUTHOR:	GOVERNOR AND MEMBERSHIP LEAD
PURPOSE:	TO NOTE FOR RATIFICATION
APPENDICES	ANNEX 1: record of virtual votes and outcome

BACKGROUND AND EXECUTIVE SUMMARY

This report provide a report on the virtual votes carried out since the last Council meeting for ratification of the decisions taken. In all cases the criteria applied was that the vote would be passed if 65% of Governors vote for the motion and at least 70% of all governors able to vote has voted.

The details of the virtual votes and the outcomes are provided at Annex 1.

LINKS TO STRATEGIC OBJECTIVES:

We care about...

- **Our patients;**
- **Our people;**
- **Our future;**
- **Our sustainability;**
- **Our quality and safety.**

RECOMMENDATIONS AND ACTION REQUIRED:

The Council of Governors is asked to note the outcomes of the virtual voting carried out since the last meeting for ratification.

Appendix 1

VIRTUAL VOTING RECORD SUMMARY						
DATE REQUESTED	DESCRIPTION	FOR	AGAINST	ABSTAIN	NUMBER OF GOVERNORS IN COUNCIL	OUTCOME
12.03.21	Appointing a Deputy Lead Governor	11	0	1	16	Passed. Ken Rogers appointed.
28.04.21	Recommendation from CoG Nominations and Remuneration Committee following interviews to appoint to three NED positions on the Board.	15	0	0	19	Passed.

DRAFT

REPORT TO:	COUNCIL OF GOVERNORS
DATE:	20 MAY 2021
REPORT TITLE:	ANNUAL PRESENTATION OF THE REGISTER OF INTERESTS AND FIT AND PROPER PERSONS DECLARATION
SPONSOR:	
PAPER AUTHOR:	GOVERNOR AND MEMBERSHIP LEAD
PURPOSE:	TO NOTE
APPENDICES	Appendix 1: Register of interests (below)

BACKGROUND AND EXECUTIVE SUMMARY

In accordance with good governance Governors are asked to confirm their status as Fit and Proper Persons each year. There are two declarations outstanding at the time of writing this report; both governors have confirmed that these will be submitted with urgency.

The current Register of Interests is attached at Appendix 1. This is updated through the year when governors advise of a change in their circumstances. It is available to the public on the Trust's website.

LINKS TO STRATEGIC OBJECTIVES:

We care about...

- **Our patients;**
- **Our people;**
- **Our future;**
- **Our sustainability;**
- **Our quality and safety.**

RECOMMENDATIONS AND ACTION REQUIRED:

The Council of Governors is asked to NOTE this report

APPENDIX 1**REGISTER OF COUNCIL OF GOVERNOR INTERESTS 2021/22****As at 20 May 2021**

NAME AND CONSTITUENCY	TERM ENDS	INTERESTS DECLARED	NOTES
BAXTER LIZ Elected (Folkestone & Hythe)	28 FEBRUARY 2023	None	Elected August 2020 (1 st term)
BAYFORD, ROBERT Partnership (Local Authorities)	29 FEBRUARY 2024	Member of the Conservative Party (6)	Appointed May 2019 (1 st term) Re-Appointed March 2021
BRITTON ROSS Elected (Swale)	29 FEBRUARY 2024	None	Elected March 2021 (1 st Term)
CASHA, JAMES (Staff)	29 FEBRUARY 2024	Kendal Meadow Ltd (Director) (1) Member of Faculty, AO UK Trauma (5) Practising privileges at Spencer Private Hospital (6) Practising privileges at BMI Chaucer Hospital (6)	Elected March 2021 (1 st Term)

NAME AND CONSTITUENCY	TERM ENDS	INTERESTS DECLARED	NOTES
		Medical Advisory Committee, Spencer Private Hospitals – Member (6)	
FLETCHER JOHN Elected (Ashford)	29 FEBRUARY 2024	None	Elected March 2021 (2 nd Term)
HULME, NICK (Ashford)	28 FEBRUARY 2023	None	Elected March 2020 (1 st Term)
JUDD LINDA Partnership (Volunteers)	9 FEBRUARY 2024	League of Friend, QEQM, Member & Trustee (5)	Appointed 9 February 2021 (1 st term)
LISTER, ALEX Elected (Canterbury)	29 FEBRUARY 2024	Director, Canterbury Digital Ltd (1) Member of the Liberal Democratic Party (6)	Elected March 2018 (1 st Term) Re-Elected March 2021
MAYALL, BERNIE (Dover)	29 FEBRUARY 2024	Director Mayall Management Ltd (Owner, Management Consultancy) (2) NED Nest+Grow (CiC) COO User Voice (NFP)	Took post 23.03.19 following the resignation of previous governor. (1 st Term)

NAME AND CONSTITUENCY	TERM ENDS	INTERESTS DECLARED	NOTES
		Director and Deputy Chair Dover Big Local (CiC) (4) Academy for Social Justice (Board Member) (4)	Re-Elected March 2021
PETTIFER, SOPHIE (Staff)	29 FEBRUARY 2024	None	Elected March 2021 (1 st Term)
PINK CHRIS Elected (Rest of England & Wales)	29 FEBRUARY 2024	Transflo Instruments Ltd (technical Director) (1) Friends of Inyathi Hospital (Trustee technical) (5)	Elected March 2021 (1 st Term)
PLUMMER, CARL (Folkestone & Hythe)	29 FEBRUARY 2024	Kent Community Health NHS FT, Member (5) South East Coast Ambulance Service NHS FT, Member (5)	Took post 02.09.19 following the resignation of previous governor. (1 st Term) Re-Elected March 2021
RICKETTS ALEX Elected (Canterbury)	28 FEBRUARY 2023	Member of the Liberal Democratic Party (6)	Took post 01.03.21 following the resignation of previous governor. (1 st Term)

NAME AND CONSTITUENCY	TERM ENDS	INTERESTS DECLARED	NOTES
ROGERS, KEN Elected (Swale)	OCTOBER 2021	None	Elected March 2018 (3 rd Term: non-consecutive) Elected March 2021, 8 years 4 months served of maximum 9 years allowed by Trust Constitution
SCHOFIELD, PAUL (Thanet)	28 FEBRUARY 2023	None	Elected March 2020 (1 st Term)
TOWSE, DEBRA Partnership (Canterbury Christ Church University and University of Kent)	31 OCTOBER 2023	Pro-Vice-Chancellor and Dean of Faculty of Medicine, Health and Social Care Charity Trustee - Council of Deans for Health Registered Charity No. 1001127 Director - Company Limited by Guarantee Council of Deans for Health No. 2517018	First nominated 1 November 2014. (now on 3 rd term)

NAME AND CONSTITUENCY	TERM ENDS	INTERESTS DECLARED	NOTES
VERRILL, PAUL (Dover)	29 FEBRUARY 2024		Elected March 2021 (1 st Term)
WARBURTON, MARCELLA Elected (Thanet)	28 FEBRUARY 2023	Member, Healthwatch Kent (4) Health Reference Group, Thanet CCG (4) Royal British Legion, caseworker (4) Volunteer, QEQM (4)	Elected March 2020 (3 rd Term)
WILSON, SALLY (Staff)	28 FEBRUARY 2023	None	Elected March 2020 (1 st Term)

Categories:

- 1 Directorships** – Executive & Non-Executive – held in private companies or PLCs with the exception of dormant companies

- 2 **Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS** – of Private Companies, Businesses or Consultancies likely or possibly seeking to do business with the NHS
- 3 **Majority or controlling shareholding** – in organisations likely or possibly seeking to do business with the NHS
- 4 **Position(s) of authority in a charity or voluntary body** – in a field of Health and Social Care
- 5 **Any connection with a voluntary or other body contracting for NHS services**
- 6 **Membership of a political party**

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REPORT TO:	COUNCIL OF GOVERNORS
DATE:	20 MAY 2021
REPORT TITLE:	ANNUAL GOVERNANCE UPDATE
BOARD SPONSOR:	GROUP COMPANY SECRETARY
PAPER AUTHOR:	GROUP COMPANY SECRETARY
PURPOSE:	NOTE
APPENDICES	APPENDIX 1: NHSE/I TIMETABLE LETTER FOR SUBMISSION OF ANNUAL DOCUMENTS

BACKGROUND AND EXECUTIVE SUMMARY

Annual Report and Accounts

In light of pressures caused by the public sector response to COVID-19, some annual report requirements have been changed for 2020/21. In many areas changes to the *FT ARM* are constrained by the extent of changes being made to *The Government Financial Reporting Manual* by HM Treasury.

In summary the changes are:

- The annual report is no longer required to include a performance analysis section within the performance report. This is optional.
- The annual report is no longer required to include a quality report. This is optional.
- The staff sickness disclosure in the staff report can be replaced with a link to where the information will be available online.
- The model annual governance statement is updated to reflect the change to preparation of quality reports.

The timetable for delivery of the Annual Report and Accounts is attached as appendix 1. For reference the usual submission date is around the end of May and this has been extended until the end of June. The Board will be holding a private meeting on 23 June 2021 to approve the documents.

It should be noted that the documents remain confidential until laid before Parliament and at present laying instructions have not been provided. However, NHSIE will assume the accounts to be in the public domain from 21 September 2021; this impacts on the holding of the Annual Members' Meeting and Annual General Meeting (which are usually held together in September) as this cannot be held until the documents are made public. We will therefore work on the basis of an AMM / AGM after 21 September 2021.

Quality Account

Governors will be aware of the usual requirement to prepare and submit a Quality Account. However, NHS Providers were advised, wrongly, that there was going to be a legislative change for 2020-21 which would change the requirements. However, this did not come to fruition and the requirement remains that the Quality Account should be prepared and

uploaded by 30 June 2021. The Trust is working towards this date but NHSIE has confirmed that there will be no penalty for Trust's who are unable to make this deadline.

The Quality Committee has endorsed the need for additional resource to support the drafting of the Quality Account to mitigate the tight deadline. I will keep Governors updated on progress. Given the number of new Governors we will be organising NHS Providers to give some training on the preparation of the Governor Commentary which we hope you will find helpful.

Statutory Annual Declarations

All trusts are expected to undertake an annual review of compliance with the Provider Licence, NHSIE has confirmed there will be no audit of this work undertaken this year and no penalties imposed for late delivery. They have also noted that Trust's may not have complied with some aspects of their licence or Code of Governance due to the pandemic (and as agreed with NHSIE) and this should be documented. The compliance statements will be discussed at the Board Committees and Board during May and June 2021.

One area for the Governors to note is that NHSIE agreed that Council work should be stood down during the pandemic; whilst the Trust tried to maintain engagement with the Council throughout one area of the compliance statement focusses on Governor Training and the Trust will be stating it was non-compliant with this aspect for the reasons noted above; the statement will then outline the training proposed for next year which will be discussed with Council.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	None identified	
LINKS TO STRATEGIC OBJECTIVES:	We care about... <ul style="list-style-type: none"> • Our patients; • Our people; • Our future; • Our sustainability; • Our quality and safety. 	
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	As outlined above.	
RESOURCE IMPLICATIONS:	None	
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Board's IAGC	
SUBSIDIARY IMPLICATIONS:	None identified	
PRIVACY IMPACT ASSESSMENT: <i>No</i>	EQUALITY IMPACT ASSESSMENT: <i>No</i>	

RECOMMENDATIONS AND ACTION REQUIRED:

The Council of Governors is asked to NOTE the report.

15 January 2021

Dear Colleague

NHS accounts timetable and year-end arrangements – with provider annex

Understanding the challenges

The NHS is under considerable strain so we must collectively focus on the essentials. You will appreciate that maintaining financial control and reporting is vital, and this is most straightforward for entities when it is timely rather than retrospective. Month 9 reporting helps ensure the smooth running of year end, but we are mindful of the wider pressures. Our plan is that month 9 continues, but we are seeking to simplify or remove other requirements in the lead up to year end as this letter explains.

Many of you have told us that the 2019/20 year end went on too long: despite the pressures of the pandemic, you would have liked accounts and audit deadlines to have been less protracted. In planning for 2020/21 many of you have given the same message. Some entities with significant additional operations with a direct impact on financial reporting have told us they would not want an extended year end. Others have made clear to us that they do need more time. The complexity of intra-group arrangements within the Department of Health and Social Care (DHSC) group means the 'agreement of balances' exercise and associated submissions remains necessary, and this only works when entities work to the same timescales. But we need to make this as straightforward as possible. In addition, the audit community continues to report pressures from remote working and impact from delays in other sectors including local government.

Year end timetable for 2020/21

The draft accounts deadline for NHS bodies is 27 April. This reflects the timing of Easter and adds a further working day compared to the previous practice in 2018/19 and earlier years. It then extends the audit window by two weeks, to 15 June. This is in recognition of the delays caused if auditors need to perform their work remotely. We do not know if this will be the case, but it is prudent to plan that it may be. If audits revert to being conducted mainly on-site, we will keep this timetable as proposed.

Some provider organisations might need more time for their year end, and affected bodies will be able to apply for this. Examples of circumstances that might give rise to this include:

- a significant change to the operations of the trust and associated workload for accounts preparation, for example hosting a Nightingale facility or



- a material merger/acquisition transaction in the final three months of the financial year.

This extended year end for applicable providers will be a submission of draft accounts by 11 May 2021 (and any time from 3 May onwards), and then an audited accounts deadline of 29 June 2021, regardless of when draft accounts were submitted in that window. Agreement of balances submissions are still required on 27 April and 11 May. To help auditors plan their year end workloads, any provider organisations wishing to apply for this extended timetable should do so by email to Provider.Accounts@improvement.nhs.uk by 19 March, with a brief explanation for the request.

	Main timetable for NHS providers and CCGs	Extended timetable for specific NHS providers where agreed in advance per above
Providers: deadline for applying for extended accounts timetable	n/a	Apply on or before 19 March 2021 by email to Provider Accounts. Decisions issued within 3 working days.
First main submission at month 12	27 April 2021: submission of draft accounts and agreement of balances data	27 April 2021: agreement of balances data only
Extended timetable for specific providers: draft accounts window	n/a	Between 3 May and 11 May 2021: submission of draft accounts and accompanying Provider Finance Return (PFR) form
Agreement of balances resubmission	11 May 2021: agreement of balances resubmission	11 May 2021: agreement of balances resubmission
Audited accounts submission	15 June 2021 including updated agreement of balances data	29 June 2021 including updated agreement of balances data

IFRS 16 Leases

In light of the current pressures faced by NHS finance teams, in November we asked HM Treasury and the Financial Reporting Advisory Board (FRAB) to agree to a further deferral of IFRS 16 for the NHS and this was agreed. IFRS 16 will be adopted in the NHS from 1 April 2022. We will provide more information on our plans for this in summer 2021.

Simplifying agreement of balances

The thresholds for agreeing statements have been raised for month 9 2020/21. Agreement is now required for statements totalling **£300,000** or more, compared to a previous threshold of £100,000 at month 9. Agreement thresholds for month 12 2020/21 will remain at the higher level introduced in 2019/20. This is £5 million for income and £500,000 for receivables.

These increased thresholds along with the changes to the financial architecture in 2020/21 and the use of block payments are expected to simplify the agreement of balances process for this year.

Streamlining annual reports

The options available to NHS bodies to simplify parts of their annual reports in 2019/20 will be available again in 2020/21. This includes areas like omitting a detailed performance analysis section. These updates have been confirmed for NHS trusts and CCGs in an update to the DHSC Group Accounting Manual (DHSC GAM) for 2020/21. The Foundation Trust Annual Reporting Manual (FT ARM) 2020/21 will be published shortly.

Quality accounts, quality reports and assurance for providers

The requirements and deadlines for **quality accounts** are prescribed in regulations and are not controlled by NHS England and NHS Improvement. DHSC is currently reviewing whether regulations should be amended to revise the 30 June quality accounts deadline for 2020/21.

Continuing the revised arrangements put in place last year, NHS foundation trusts are no longer required to include a **quality report** in their annual report. This will be confirmed in the FT ARM for 2020/21. This will continue for 2021/22 and beyond, with focused reporting on quality priorities and performance in the annual report incorporated directly into the performance report. It is proposed this will be the same for NHS trust annual reports from 2021/22 in the DHSC GAM. More details will be provided in the 2021/22 reporting manuals.

NHS foundation trusts are not required to commission assurance on their quality report for 2020/21. NHS trusts are not expected to commission assurance on their quality account. From 2021/22 onwards this assurance exercise will be optional for all providers. We will update our guidance document to provide a framework for this.

Local audit

There continues to be constrained capacity in the local audit market. Existing pressures caused by changes in auditing standards and commercial decisions in the market from some firms are compounded at present by enhanced 'value for money' work and delays to audits in all sectors caused by the pandemic and remote working. Further information on auditors' expanded 'value for money' work is available from the National Audit Office: <https://www.nao.org.uk/code-audit-practice/>.

Changes in the market means many firms have a reduced risk appetite; this together with capacity means audit fees have increased in recent years. When seeking to appoint external auditors, good procurement is essential:

- allow enough time for bidders to receive and respond to the request for proposals
- ensure appropriate evaluation criteria: if the price percentage is too high it may dissuade potential bidders
- ensure you show good understanding of external audit and its value.

All NHS organisations have a statutory responsibility to appoint an external auditor. Further information is provided in our guidance available at <https://www.england.nhs.uk/financial-accounting-and-reporting/audit-and-assurance-a-guide-to-governance/>.

Next steps

Thank you for your continued work on the month 9 process. For commissioners, queries on the CCG_CSU template and any other year end related matters should be addressed to england.yearendaccounts@nhs.uk.

For providers, any queries on the 'TAC' part of the form should be addressed to Provider.Accounts@improvement.nhs.uk and queries on any other part of reporting requirements should be addressed to NHSI.sector.reporting@nhs.net or NHSI.CapitalCashQueries@nhs.net as appropriate.

Yours sincerely



Adrian Snarr
Director of Financial Control

Annex: Detailed year-end timetable

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Provider Annex: Accounts and reporting timetable for 2020/21

Organisations should note the following definitions:

- **Receivable organisation** - this is the organisation sending the invoice/is carrying the trade receivable/is receiving the income i.e. the supplier or provider
- **Payable organisation** – this is the organisation receiving the invoice/carrying the trade payable/recording expenditure i.e. the purchaser or commissioner.

We have colour-coded rows in this table as follows:

White row	Agreement of balances process
Yellow row	Monthly monitoring submission
Blue row	'Key data' submission
Green row	TAC / accounts / agreement of balances submission to NHS Improvement
Red row	Other process
Grey row	Month 12 form release by NHS Improvement

Date (by end of day unless stated)	Detail
Between 4 th January and 26 th February 2021	Submit NHS Pensions requests for senior managers' remuneration ('Greenbury') Please note that all requests for disclosure information must be received by NHS Pensions within their timeframe to enable the necessary information to be provided in time for the submission of draft accounts. NHS Pensions is unable to guarantee that requests or queries received after the deadline will be dealt with in time for draft accounts submissions.
Friday 15 th January 2021	Final date for agreement of outstanding Receivables/Payables dated up to 31st December 2020 and above £300,000.
Tuesday 19 th January 2021	Final date for Receivable organisations to e-mail Payable organisations an income statement detailing income received to 31 st December 2020. The statement will include income that has been invoiced and income received without an invoice. Only one statement must be sent to each Payable organisation. A statement must be sent to each Payable organisation even if the balance is under £300,000 but need not be sent if the balance is less than £10,000. Agreement is not required where the total balance is below £300,000.
Wednesday 20 th – Friday 22 nd January 2021	If an income statement has not been received, the Payable organisation is to inform the Receivable organisation. In such cases, the Receivable organisation must email a statement immediately.
Tuesday 26 th January 2021 (noon)	NHS providers submit month 9 Provider Finance Return (PFR) to NHS Improvement (incorporating Trust Accounts Consolidation (TAC) schedules), with first submission of month 9 receivables and payables AoB data These TACs should be prepared using the agreed receivables/payables position, but the provider's own information on income and expenditure. This submission will be used for consolidating the TACs, and for receivables and payables AoB information . The income and expenditure columns in the WGA tabs (TAC61-TAC64) will not be used in this submission, but the provider should ensure there are no validation errors in the form ¹ .

¹ The income and expenditure columns on the WGA sheets (TAC60-TAC64) are not used by NHS Improvement in this first submission. However the WGA balances columns on TAC60-TAC64 and all the counterparty columns on the accounts tabs must be properly completed. It is therefore a matter for the trust whether the income and expenditure columns on TAC60-TAC64 are completed with the

Date (by end of day unless stated)	Detail
	<p>Template to be uploaded to the NHS Improvement Portal outbox. Ensure that 'Month 9 main submission' is selected on the cover of the PFR file before uploading.</p> <p>Any financial commentary or other documents that accompany the template should be uploaded to the NHS Improvement Portal outbox with activity type 'In Year Returns', template type 'Finance Commentary' and period M09.</p>
Thursday 28 th January 2021	<p>NHS Improvement issues provider to provider mismatch reports (receivables and payables only). This report will give earlier sight of provider to provider mismatches in advance of DHSC group mismatch reports being issued.</p>
Monday 1 st February 2021	<p>NHS Improvement distributes DHSC group mismatch schedules to NHS providers (receivables and payables only)</p>
Thursday 4 th February 2021	<p>Final date for agreement of income and expenditure above £300,000 in respect of invoices dated up to 31 December 2020.</p>
Monday 8 th February 2021 (noon)	<p>NHS providers submit first submission of month 9 income and expenditure AoB to NHS Improvement</p> <p>This submission is made by resubmitting the month 9 PFR file. You should submit the whole form, but only the WGA information will be utilised from this submission (a first submission of income and expenditure). The accounts and in-year monitoring information will not be used and need not be updated. Validation errors can be ignored in this submission, except for the specific agreement of balances validations referred to on the 'Cover' sheet of the form. Please note that a submission is required from all providers, even if no AoB data has changed.</p> <p>Receivables and payables AoB information can also be included but this is not a formal receivables and payables resubmission.</p> <p>Template to be uploaded to the NHS Improvement Portal outbox. Please ensure that 'Agreement of balances resubmission' is selected on the cover of the PFR file before uploading.</p>
Wednesday 10 th February 2021	<p>NHS Improvement issues provider to provider mismatch reports</p> <p>This report will give earlier sight of provider to provider mismatches in advance of DHSC group mismatch reports being issued.</p>
Monday 15 th February 2021	<p>NHS Improvement distributes DHSC group mismatch schedules to NHS providers</p>
Monday 15 th February 2021 (noon)	<p>Submission of month 10 monitoring return to NHS Improvement</p> <p>Template to be uploaded to the NHS Improvement Portal outbox.</p> <p>Any financial commentary or other documents that accompany the template should be uploaded to the NHS Improvement Portal outbox with activity type 'In Year Returns', template type 'Finance Commentary' and period M10.</p>
Thursday 25 th February 2021 (noon)	<p>NHS providers submit second submission of month 9 income/expenditure and receivables/payables AoB to NHS Improvement</p> <p>This submission is made by resubmitting the month 9 PFR file. You should submit the whole form, but only the WGA information will be utilised from this submission. The accounts and in-year monitoring information will not be used and need not be updated. Validation errors can be ignored in this submission, except for the specific agreement of</p>

provider's own information, or balancing figures are entered to clear the I&E WGA validations: the counterparty columns on the main TAC tabs must be fully completed. The month 9 TAC completion instructions gives guidance on the form, this includes which specific notes and tables in the accounts tabs can be omitted.

Date (by end of day unless stated)	Detail
	balances validations referred to on the 'Cover' sheet of the form. Please note that a submission is required from all providers, even if no AoB data has changed. Template to be uploaded to the NHS Improvement Portal outbox. Please ensure that 'Agreement of balances resubmission' is selected on the cover of the PFR file before uploading.
Friday 26 th February 2021	Final deadline for submitting requests for senior managers' remuneration information ('Greenbury') to NHS Pensions – see information above
Monday 1 st March 2021	NHS Improvement issues provider to provider mismatch reports This report will give earlier sight of provider to provider mismatches in advance of DHSC group mismatch reports being issued.
Thursday 4 th March 2021	NHS Improvement distributes DHSC group mismatch schedules to NHS providers Providers should use these reports to manage the resolution of any remaining variances before the year end agreement of balances process.
Monday 15 th March 2021 (noon)	Submission of month 11 monitoring return to NHS Improvement Template to be uploaded to the NHS Improvement Portal outbox. Any financial commentary or other documents that accompany the template should be uploaded to the NHS Improvement Portal outbox with activity type 'In Year Returns', template type 'Finance Commentary' and period M11.
Friday 19 th March 2021	Deadline for providers to apply to NHS Improvement for extended year end timetable As explained in the letter above, this is the deadline for providers to email Provider.Accounts@improvement.nhs.uk to request the extended year end timetable, with brief information on reason for request (see letter). We will reply to each request within three working days.
Tuesday 23 rd March 2021	Final date for sending March dated invoices (email where possible). These invoices relate to activity and services up to and including February and should include estimates for March activity and services where possible.
Tuesday 23 rd March 2021	NHS Improvement issues month 12 PFR form (including TAC schedules) Month 12 forms will be issued to providers together with completion instructions. The form will be issued via the Portal inbox and accompanied by an email from Provider Accounts (Provider.Accounts@improvement.nhs.uk).
Wednesday 24 th March 2021	Final date for despatch of payments to DHSC group bodies for 2020/21. This means that there should be no payments made after 24 th March 2021 without prior agreement.
Monday 29 th March 2021	Date for Receivable organisations to e-mail Payable organisations a receivables statement detailing outstanding invoices dated and invoiced by 23 rd March 2021. Payments received up to and including 24 th March 2021 must also be included. Please note: <ul style="list-style-type: none"> • Only one statement must be sent to each Payable organisation • A statement must be sent to each Payable organisation even if the balance is under £500,000 but need not be sent if the balance is less than £2,500. Agreement is not required where the total balance is below £500,000.
Tuesday 30 th March –Thurs 1 st April 2021	If a receivables statement has not been received the Payable organisation is to inform the Receivable organisation. In such cases, the Receivable organisation must email a statement immediately.
Friday 9 th April 2021	Final date for agreement of outstanding Receivables/Payables dated up to 23 rd March 2021 and above £500,000.

Date (by end of day unless stated)	Detail
Friday 9 th April 2021	Final date for Receivables organisations to email a statement of Accruals to the Payable organisations, listing all 2020/21 liabilities not invoiced by 23 rd March 2021.
Friday 9 th April 2021	<p>Final date for Receivable organisations to e-mail Payable organisations an income statement detailing income invoiced/received to 23rd March 2021.</p> <p>The statement will include income that has been invoiced and income received without an invoice e.g. Grants, R&D payments etc. Only one statement must be sent to each Payable organisation.</p> <p>An income statement must be sent to each Payable organisation for balances over £5m and agreement reached. Receivable organisations may issue statements below this level if they wish.</p>
Monday 19 th April 2021	<p>Deadline for agreement of income/expenditure above £5m balance.</p> <p>Complete discussions regarding accruals for inclusion in 2020/21 accounts.</p>
Date to be confirmed (for queries contact Sector Reporting)	<p>Submission of month 12 'key data' return to NHS Improvement</p> <p>Template to be uploaded to the NHS Improvement Portal outbox.</p> <p>Please note 'Key Data' submissions are to allow early view of high-level figures. We would not expect any material changes to these key figures unless this has been agreed with your NHS improvement regional contact first.</p>
Tuesday 27 th April 2021 (noon)	<p>NHS providers submit month 12 PFR form (including unaudited TACs) and draft accounts to NHS Improvement</p> <p>This submission is of:</p> <ul style="list-style-type: none"> • Month 12 PFR form (including unaudited TACs) • Draft accounts <p>The TACs will include income/expenditure and receivables/payables WGA data. PFR form uploaded to the NHS Improvement Portal (outbox). Please ensure that 'Draft accounts' is selected on the cover of the PFR file before uploading.</p> <p>There should be no validation errors in this submission.</p> <p>Draft accounts uploaded to the NHS Improvement Portal outbox and submitted as:</p> <ul style="list-style-type: none"> • Financial year: FY2020-21 • Activity: In Year Returns • Template Type: Accounts submissions • Period: M12 <p>Any financial commentary that accompanies the template should be uploaded to the NHS Improvement Portal outbox with activity type 'In Year Returns', template type 'Finance Commentary' and period M12.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><u>For providers following extended year end timetable (see letter above)</u></p> <p>This date is a first submission of agreement of balances (receivables and payables and income and expenditure) data to NHS Improvement. This submission is made by submitting the month 12 PFR file. You should submit the whole form, but only the WGA information (TAC61 – TAC64) will be utilised from this submission. The accounts and in-year monitoring information will not be used and can be submitted in any partially completed state. The cover of the PFR form will list the validations to be passed if this option is taken.</p> <p>PFR form uploaded to the NHS Improvement Portal outbox. Please ensure that 'Agreement of balances only' is selected on cover of PFR file before uploading.</p> </div>

Date (by end of day unless stated)	Detail
Thursday 29 th April 2021	<p>NHS Improvement issues provider to provider mismatch reports</p> <p>This report will give earlier sight of provider to provider mismatches in advance of DHSC group mismatch reports being issued.</p>
Tuesday 4 th May 2021	<p>NHS Improvement distributes DHSC group mismatch schedules to NHS providers</p>
<p>For applicable providers only</p> <p>Between 3 May and 11 May 2021 (noon)</p>	<p>For providers following the extended year end timetable: Submission of month 12 PFR form (including unaudited TACs) and draft accounts to NHS Improvement</p> <p>This submission is of:</p> <ul style="list-style-type: none"> • Month 12 PFR form (including unaudited TACs) • Draft accounts • Updated WGA balances and transactions data in relevant TAC tabs. Note that the agreement of balances data in this form will not inform mismatch reports, but it must reconcile with accounts data in order to inform subsequent updates. <p>PFR form uploaded to the NHS Improvement Portal (outbox). Please ensure that ‘Draft accounts’ is selected on the cover of the PFR file before uploading.</p> <p>There should be no validation errors in this submission.</p> <p>Draft accounts uploaded to the NHS Improvement Portal outbox and submitted as:</p> <ul style="list-style-type: none"> • Financial year: FY2020-21 • Activity: In Year Returns • Template Type: Accounts submissions • Period: M12 <p>Any financial commentary that accompanies the template should be uploaded to the NHS Improvement Portal outbox with activity type ‘In Year Returns’, template type ‘Finance Commentary’ and period M12.</p>
Tuesday 11 th May 2021 (noon)	<p>NHS providers re-submit TACs to provide updated agreement of balances information to NHS Improvement</p> <p>This submission is made by resubmitting the month 12 PFR file. You should submit the whole form, but only the WGA information will be utilised from this submission. The accounts and in-year monitoring information will not be used and need not be updated. Validation errors can be ignored in this submission, except for the specific agreement of balances validations referred to on the ‘Cover’ sheet of the form. Please note that a submission is required from all providers, even if no AoB data has changed.</p> <p>Template to be uploaded to the NHS Improvement Portal outbox. Please ensure that ‘Agreement of balances only’ is selected on the cover of the PFR file before uploading. Any changes to the accounts must be agreed with your auditors and should form part of the audited submission of the accounts and PFR form on 15th June.</p> <div data-bbox="379 1621 1442 1809" style="border: 1px solid black; padding: 5px;"> <p><u>For providers following extended year end timetable (see letter above)</u></p> <p>All providers need to make an agreement of balances submission on 11 May per this row, <u>unless</u> your draft accounts were submitted on 10 or 11 May and you have no further AoB updates. Please inform us at Provider Accounts if this is the case for you.</p> </div>
Thursday 13 th May 2021	<p>NHS Improvement issues provider to provider mismatch reports</p> <p>This report will give earlier sight of provider to provider mismatches in advance of DHSC group mismatch reports being issued.</p>
Monday 17 th May 2021	<p>NHS Improvement distributes DHSC group mismatch schedules to NHS providers</p>

Date (by end of day unless stated)	Detail			
<p>Tuesday 15th June 2021 (noon)</p> <p><u>For providers following extended year end timetable (see letter above)</u></p> <p>For these providers this date is Tuesday 29th June 2021 (noon)</p>	NHS providers submit month 12 PFR form (including audited TACs) and audited accounts to NHS Improvement			
			Electronic (Portal)	Electronic (Portal) scan (pdf) of a signed document. In all cases electronic signature(s) included in PDF are acceptable
	1	Audited accounts	✓ (Any reasonable file type)	
	2	Audited accounts: signed Statement of Financial Position (balance sheet)		✓
	3	Audited accounts: signed Statement of Accounting / Accountable Officer's Responsibilities		✓
	4	Audited TAC schedules (submission of PFR form)	✓	
	5	Audited TAC schedules: Print or screenshot of the 'Confirmations' tab and signed* at the bottom by the Chief Executive as confirmation that the final audited TAC schedules have been submitted. Please ensure answer to question 3 has been updated. *For 2020/21, typing in the Chief Executive's name in the box is sufficient. See TAC form.		✓
	6	Full final text of 'audited' annual report (this does not need to have final formatting for printing, but should be the final text)	✓	
	7	Annual report: signed pages <ul style="list-style-type: none"> For FTs: see annex 1 to chapter 1 of the FT ARM For NHS trusts: see DHSC GAM paragraphs 3.8 and 3.9) 		✓ (No need to upload separately if the file in (6) is a pdf containing signatures)
	8	Auditor ISA 260 report	✓	
	9	Original signed audit report (audit opinion) on the accounts		✓ For avoidance of doubt – Electronic signature included in PDF is acceptable here as well.
	10	Original signed chief executive and finance director certificate on the summarisation schedules (TAC schedules)		✓
11	Auditor report on the summarisation schedules (TAC schedules)		✓	
This row continues overleaf				

Date (by end of day unless stated)	Detail
	<p>The TACs will include income/expenditure and receivables/payables WGA data.</p> <p>PFR form uploaded to the NHS Improvement Portal (outbox). Please ensure that 'Audited accounts' is selected on the cover of the PFR file before uploading.</p> <p>There should be no validation errors in this submission.</p> <p>All other electronic submissions in table above uploaded to the NHS Improvement Portal outbox and submitted as:</p> <ul style="list-style-type: none"> • Financial year: FY2020-21 • Activity: In Year Returns • Template Type: Accounts submissions • Period: M12
TBC	<p>FOR NHS FOUNDATION TRUSTS ONLY</p> <p>Laying NHS foundation trust annual report and accounts before Parliament</p> <p>We will provide deadlines and details for NHS foundation trusts laying their annual reports and accounts before Parliament later in the year.</p>
TBC	<p>FOR ALL NHS PROVIDERS</p> <p>NHS providers reply to NHS Improvement's letter regarding events after the reporting date. We will provide details of this process later in the year.</p>
For NHS trusts and NHS foundation trusts: Monday 20 th September 2021	<p>FOR ALL NHS PROVIDERS: NHS providers submit final full annual report including full statutory accounts to NHS Improvement</p> <p>This should be a <u>single PDF document</u> containing both the annual report and full statutory accounts including audit report (opinion).</p> <p>Uploaded to the NHS Improvement Portal outbox:</p> <ul style="list-style-type: none"> • Financial year: FY2020-21 • Activity: In Year Returns • Template Type: Accounts submissions • Period: M12
Monday 20 th September 2021	<p>FOR NHS TRUSTS ONLY: NHS trusts to publish Annual Report and accounts</p> <p>Each NHS trust should make its 2020/21 annual report and accounts available on its website. As guided by the DHSC GAM, an NHS trust may choose to additionally publish a "performance report overview and supplementary material". If this document is published on the trust's website, it must include a statement on how the user can obtain the full annual report and accounts.</p> <p>In either case, NHS Improvement will consider NHS trusts' accounts data to be in the public domain after 20th September 2021.</p>

Annex 2: Summarised timetable for 2020/21

Collection period	Information collected	NHS Improvement issues forms via portals (by end of day)	Submission deadline for providers (by noon unless otherwise stated)
Month 8	PFR form: monthly monitoring	Friday 4 th December 2020	Tuesday 15 th December 2020
Month 9: Main submission	PFR form: TAC schedules and monthly monitoring	Tuesday 22 nd December 2020	Tuesday 26 th January 2021
Month 9: AoB submission	PFR form: TAC schedules (WGA sheets updated only)	n/a	Monday 8 th February 2021
Month 9: AoB resubmission	PFR form: TAC schedules (WGA sheets updated only)	n/a	Thursday 25 th February 2021
Month 10	PFR form: monthly monitoring	Tuesday 4 th February 2021	Monday 15 th February 2021
Month 11	PFR form: monthly monitoring	Tuesday 4 th March 2021	Monday 15 th March 2021
Month 12 Key Data	PKD form: Key data	TBC	TBC
Month 12: Draft Accounts	PFR form: TAC schedules and monthly monitoring	Tuesday 23 rd March 2021	Tuesday 27 th April 2021 (Or Tuesday 11 th May for those agreed as being on extended timetable: see annex 1)
Month 12: AoB submission	PFR form: TAC schedules (WGA sheets updated only)	n/a	Tuesday 11 th May 2021
Month 12: Final Accounts	PFR form: TAC schedules and monthly monitoring	n/a	Tuesday 15 th June 2021 (Or Tuesday 29 th June for those agreed as being on extended timetable: see annex 1)

REPORT TO:	COUNCIL OF GOVERNORS
DATE:	20 MAY 2021
REPORT TITLE:	CHAIRMAN'S REPORT
SPONSOR:	TRUST CHAIRMAN
PAPER AUTHOR:	GOVERNOR AND MEMBERSHIP LEAD
PURPOSE:	TO DISCUSS
APPENDICES	Appendix 1 Proposed Council meeting schedule and workplan (below) Appendix 2 – MECC terms of reference Appendix 3 – NRC, terms of reference Appendix 4 – S&PEC, terms of reference Appendix 5 – AGC, terms of reference Appendix 6 – Draft Annual meeting schedule and planner

BACKGROUND AND EXECUTIVE SUMMARY

This report provides an update to Council on significant issues and includes a discussion document to enable governors to consider and agree how to structure their time and resources moving forward in order to best meet Council's roles and responsibilities (Appendix 1, below).

Welcome

It is a great pleasure and privilege to chair this Council. I have now had a chance to meet nearly every one of you individually and it is great to see not only the passion and commitment you bring to this role, but also the wide range of knowledge and experience you possess, which will be of such value to the Council and to the Trust as a whole.

There are brilliant people working for this organisation delivering superb care, and I know all of us want to do everything we can to support and encourage them. We also know many are exhausted and traumatised by the events of the past year and that, as an organisation, we have a great deal to do to make sure we create the right culture and conditions to enable all our staff to deliver excellent care in every service we provide. And to achieve that, all of us in leadership positions, be we governors, non-executives or executives, have a vital role to play. I am excited that we can now embark on that journey together.

This is my first meeting chairing Council, and the first in some time with no vacancies. What is more, thanks to the sterling work of the Council's Nomination and Remuneration Committee, next week I will be chairing a Trust Board with a full complement of Non-Executive Directors (NEDs) and shadowing arrangements in place. The last year has been tough in so many ways including conditions where, as leaders, you could not meet each other face to face or importantly visit clinical areas. It now looks as if those restrictions are coming to an end and I very much hope the next period will be an opportunity to re-set relationships between the Board and Council and re-engage with patients, with staff and with each other across the organisation. I very much look forward to working with you and the Board to achieve that.

Council of Governors framework

To begin this work, at Appendix 1 there is a paper which sets out a draft workplan and meeting schedule for Council and a proposal for how we capture information, data and feedback to enable you to deliver your overarching statutory duties to:

- Represent the interests of members and the public; and
- Hold the NEDs to account for the performance of the Board.

The aim here will be to decide how that is going to be done, making sure all aspects and all voices are considered.

Today's Agenda

The agenda for this meeting reflects that ambition and in particular I hope we can agree the Framework in Appendix 1 which will govern the way we work. The agenda contains

- 'housekeeping' items covering ,
 - governance matters, including – minutes and outstanding actions
 - annual requirements – presenting the register of interests;
- standard items such as
 - the CEO's report updating Council on significant operational issues
 - An overview report from the NEDs

For future meetings, I hope we will also have reports from the Council Committee Chairs and ad hoc items, such as the report from the Constitution and Policy Review Group.

I am meeting our Lead Governor, Alex Lister every two weeks and I hope this will be a useful way of making sure that the agenda and the approach we are taking matches your expectations. While there are items which have to be included, it is important that Council meetings provide you with the opportunity to have the discussions you need to deliver your role.

We have a packed agenda so I will have to make sure I keep us all to time, but will do everything I can to make sure everyone is able to contribute. I would welcome your feedback on how we get on today.

As I mentioned earlier, Council has had to meet virtually for over a year and we will soon need to consider when and how that should be changed. We have all experienced the benefits and challenges of virtual meetings and I want to make sure that moving forward we hold Council and Board meetings in a way which both embraces the benefits and mitigates the challenges. Again, I would welcome your thoughts on this.

LINKS TO STRATEGIC OBJECTIVES:

We care about...

- **Our patients;**
- **Our people;**
- **Our future;**
- **Our sustainability;**
- **Our quality and safety.**

RECOMMENDATIONS AND ACTION REQUIRED:

The Council of Governors is asked to:

1. discuss and agree the proposal for the framework for Council to work within;
2. agree the proposed meeting dates and schedule for the remainder of 2021/22; and
3. agree to review the framework after a full year.

Appendix 1 Council Framework

This paper has been drafted by the Corporate Support Team to provide a basis for governors to discuss and agree a framework within which they can work. It has been built on discussions at past Council meetings and invited comments from governors.

The aim of the framework is to enable Council to use information from a range of sources and to work within a committee structure which prevents duplication and allows Council to make the best use of time at its formal public and closed sessions.

Before the pandemic, Council supported the proposal from Nick Hulme, Public Governor, Ashford, that governors should agree three priority areas. Plans to develop this further were lost within all the changes of the past year, but Council may wish to re-visit this idea. It would provide a focus for our work in Council and importantly it would fit well with the We Care methodology the Trust is following.

We are proposing that, once agreed, we run the framework for a year and then review at a future meeting. The time commitment this proposal will need from Governors is significant and we will need to make sure it is sustainable. At the same time and in line with this, we will make sure that an effectiveness review is undertaken each year. We are planning a similar process for the Trust Board. It is proposed that we invite NHS Providers to undertake an effectiveness review of Council in the near future and repeated this in a year's time to provide a baseline to assess the working of Council and this framework.

Committee Structure

Note: Council cannot delegate powers to its Committees; every governor can be involved in every decision taken by Council.

Proposal:

maintain Membership Engagement and Communication Committee (MECC) and Nomination and Remuneration Committee (NRC) but separate the current Audit and Governance Committee into two, to create a Staff & Patient Experience Committee (S&PEC) and an Audit and Governance Committee (AGC). The S&PEC would take on the review of Staff and Patient experience issues and responsibility for managing the drafting of the Governors' commentary on the Trust's Quality Report, with the new AGC retaining all other elements of the current AGC terms of reference.

The Chair of each Committee would report on proceedings at their meeting to the next meeting of Council.

Suggested terms of reference

- Appendix 2 – MECC, as now
- Appendix 3 – NRC, as now
- Appendix 4 – S&PEC, revised
- Appendix 5 – AGC, revised

Committee membership

Continue with the current system of refreshing membership annually but as an item for the May Council meeting. This will give time for governors joining after the annual elections to settle into their role and decide where their interests lie.

The current practice is to have a membership of eight governors on a Committee: 6 public, one partner and one staff, with a quorum of four. Chair to be agreed by the members after

Council have agreed annual membership. All governors able to attend any meeting of a Committee. This does not include short/long listing and interviews for NED appointments carried out by the NRC.

Proposed change: membership of the NRC is not set at the start of the year but as required with governors volunteering to take part when a meeting, or series of meetings, is convened. This will be a minimum of one a year to look at NED remuneration and the skill balance on the Board, with extra meetings as required due to NED vacancies arising.

Sources of information and feedback

Type	Source	Route to Council
Information		
Performance data	Integrated Performance Report (IPR)	All public meetings: latest IPR presented to Board
Finance report	Summary report from Director of Finance	Public session of Council meetings, additional reporting to closed session as required.
Risk reporting	Risk Register	All public sessions: latest report presented to Board
	Themes and trend paper Note: this report makes reference to serious incidents	To 1. S&PEC for full discussion 2. S&PEC Chair's report to Council to summarise their discussions bearing in mind that this is a highly confidential document.
External reports, including: <ul style="list-style-type: none"> • CQC reports • National staff and patient surveys • Audit reports 	Documents when they can be available to Council or are in the public domain.	To 1. S&PEC or AGC for full discussion as appropriate 2. S&PEC and AGC Chair's reports to Council to summarise their discussions
Board meetings	Attending Public Board meetings Receiving Public Board pack and Agenda & redacted minutes of Closed Board meetings.	Will inform governor questions to NEDs at Council meetings and the NED appraisal process.
Feedback		
Board Committee meetings	NED overview report Item presented by named NED, at least one representative from each of the Board Committees to be present at the meeting. Supported by the lead Executive Director as appropriate.	Standard item on Council agenda – may need items in both public and closed sessions depending on content
Member feedback	Summary from database of member questions and	To

	feedback held by the Corporate Support team. Content provided via <ul style="list-style-type: none"> • Member email • Governor questions email • Member contact with Governors 	1. S&PEC (patient care) or MECC (engagement) for full discussion as appropriate 2. S&PEC and MECC Chair's reports to Council to summarise their discussions 3. Outcome of Council discussion, and database to be provided to Board as part of the Chairman's report.
Governor feedback	Summary from database of governor enquiries/questions held by the Corporate Support team.	To 1. S&PEC (patient care) or MECC (engagement) for full discussion as appropriate 2. S&PEC and MECC Chair's reports to Council to summarise their discussions 3. Outcome of Council discussion, and database to be provided to Board as part of the Chairman's report.
Site visits		To 1. S&PEC for full discussion 2. S&PEC Chair's report to Council to summarise their discussions 3. Outcome of Council discussion, and database to be provided to Board as part of the Chairman's report.
Member engagement Managed via the Council's Engagement strategy which is monitored by the MECC	Membership engagement strategy monitoring report presented to all MECC meetings.	CoG MECC Chair's report to Council to summarise their discussions
Governor involvement in national/trust visit programmes	<ul style="list-style-type: none"> • PLACE visits • Patient Safety visits • Training visit • Local Network meetings 	To 1. Relevant CoG committee for full discussion 2. CoG Committee Chair's report to Council to summarise their discussions

Governor engagement

Members: MECC to review Membership Engagement Strategy in light of the impact of the pandemic. This could include staff and patient surveys, member meetings (virtual or in person), governor surgeries

Site visits: re-establish a programme of site visits by joint teams of Executive Directors, NEDs and Governors. These should be at short notice and without a planned agenda; an opportunity for the team to observe the area and perhaps end with a question/answer session with a senior member of the team being observed. NEDs and Governors could be linked into teams to give an opportunity to develop relationships between Board and Council.

Gemba visits are a key part of the We Care programme; short and unannounced visits. Gemba is a Japanese term meaning ‘the actual place’. The Executive team are already undertaking these visits and it is planned to extend these to include NEDs and Governors as restrictions lift.

Solo visits by Governors have also been suggested. It is not proposed to include these within the programme at present.

Governor attendance at Board Committee meetings: this has been proposed in the past and by new governors. It is suggested that this is parked for now and considered when the framework is reviewed in a year.

Meeting schedule and annual planner

The following meetings are proposed.

- Council meetings, four a year held two weeks after a public Board meeting. Closed and public session with a 30” pre-meet between Governors and the Trust Chairman.
- Briefing meetings, monthly in the months between Council meetings; not held in January and February as the Strategy and Joint meetings are scheduled in these months. One hour in duration and to be used to feedback from Board meetings where applicable, and for short familiarisation sessions on suggested topics – for example Learning Disability and Autism training.
- Joint meeting with NEDs – half day in February.
Ross has described a practice followed in another arena where there are 3 or 4 tables of governors which are visited in turn by NEDs who give a brief informal presentation on a defined topic and then time for questions. This could be used at the joint meeting and/or elsewhere through the year.
- Annual strategy meeting – half day in January
- Annual training session – half day in July
- Annual Members Meeting – usually in September, can be any time after the Trust’s Annual Report and Accounts have been laid before Parliament.

Appendix 6

Draft for an Annual meeting schedule and planner. The planner section for the CoG Committees would need to be developed further if the framework above is agreed.

Proposed timings for remaining 2021/22 meetings, based on the schedule above, would be as below. The dates to be set as a matter of urgency based on the agreement reached at the meeting.

2021

Meeting	June	July	Aug	Sept	Oct	Nov	Dec
Council Full		Wk: 12th			Wk: 11th		Wk: 13th
Briefing Strategy	Wk 21st		Wk: 30th	Wk: 20th		Wk: 8th	
Joint AMM	Best fit in all diaries						
Training		X		Evening			
MECC	X	X			X		
SPEC	X	X			X		
AGC	X	X			X		
NRC	X	X			X		

2022

Meeting	Jan	Feb	Mar
Council			Wk: 14th
Full	-	-	
Briefing	X		
Strategy		X	
Joint			
AMM			
Training			
MECC	X		
SPEC	X		
AGC	X		
NRC	X		

DRAFT

**COUNCIL OF GOVERNORS
MEMBERSHIP ENGAGEMENT AND COMMUNICATIONS COMMITTEE
TERMS OF REFERENCE**

Constitution

The Committee is a committee of the Council of Governors. It has no delegated power to make decisions on behalf of the Council.

Purpose:

1. The Committee is responsible to the Council of Governors for the following:

Develop the Communications and Membership Strategy for approval by the Council of Governors, in consultation with the Director of Communications and Engagement, and review annually.

The Communications and Membership Strategy will include plans and objectives for:

- Membership recruitment
 - Communication with Members
 - Membership engagement
 - Promoting the role of FT Governors;
2. Oversee the implementation of the Membership Strategy and monitor progress.
 3. Provide a report on the business of the Committee to the Council of Governor meetings.

Frequency of Meetings:

Meetings of the Committee will be held on a quarterly basis.

Membership and attendance:

The Committee will consist of eight Governor members appointed every March for a one year period. Membership will be voluntary and based on skills and interest. Committee members will agree the Chairmanship of the Committee each year at their first meeting after appointment. All governors will have the right to attend Committee meetings and participate in discussions. Only members of the Committee will have voting rights.

Attendees:

Non-Executive Director: Keith Palmer
Director of Communications and Engagement: Natalie Yost or her nominated representative

Quorum:

The Committee shall be quorate when at least four Governor members of the Committee are present. Virtual attendance at meetings is accepted.

Support:

The Committee will be supported administratively by the Corporate Secretariat. It shall receive advice from the Trust Secretary, or their representative, and the Director of Communications and Engagement, or their representative.

Ratified at Full Council on 21 September 2017

**COUNCIL OF GOVERNORS
NOMINATIONS AND REMUNERATION COMMITTEE
TERMS OF REFERENCE**

Constitution

The Nominations and Remuneration Committee is a committee of the Council of Governors. It has no delegated power to make decisions on behalf of the Council.

Purpose:

1. The committee is responsible to the Council of Governors for the following:
 - Considering and making recommendations to the Council of Governors on the appointment of the Chairman and Non-Executive Directors. The Committee is to satisfy itself that its recommendations fulfil Trust needs in terms of skills and experience.
 - Agree the process for recruitment of the Chairman and Non-Executive Directors taking into account the views of the Board of Directors on the process in general and the qualifications, skills and experience required for the position.
 - For NED appointments, the Chairman of the Trust will be asked to Chair the appointments panel. For appointments to the Trust Chair position, the panel will be chaired by the SID or next senior NED.
 - The Committee will ensure appointments are based on merit and objective criteria as well as meeting the 'fit and proper' persons test described in the Provider Licence.
 - To make recommendations to the Council of Governors on the re-appointment of the Chair and/or Non-Executive Directors where it is sought and is constitutionally permissible. The Committee will look at the existing candidate against the required role description.
 - To consider and make recommendations to the Council of Governors on the remuneration and terms of appointments of the Chairman and Non-Executive Directors.
 - To contribute to an annual review of the structure, size and composition of the Board of Directors and to make recommendations for changes to the NED element of the Board of Directors to the Council of Governors where appropriate. When undertaking this review, the Committee will consider the balance of skills, knowledge and experience of the Non-Executive Directors.

2. Provide a report on the business of the Committee to the Council of Governor meetings.

Frequency of Meetings:

Meetings of the Committee will be held as and when necessary to meet the Committee's duties

Agreed: CoG September 2017

Membership and attendance:

The Committee will consist of eight Governor members appointed every March for a one year period. Membership will be voluntary and based on skills and interest. Committee members will agree the Chairmanship of the Committee each year at their first meeting after appointment.

All governors will have the right to attend Committee meetings and participate in discussions. Only members of the Committee will have voting rights.

Attendees:

One Non-Executive Director (NED), normally the Trust Chair
Trust staff: Director of HR or her representative as required.

Quorum:

The Committee shall be quorate when at least four Governor committee members are present and one NED. Virtual attendance at meetings is accepted.

Support:

The committee will be supported administratively by the Corporate Secretariat and receive professional advice from the Director of HR/Corporate Services, the Chairman and the Trust Secretary.

DRAFT

Agreed: CoG September 2017



**COUNCIL OF GOVERNORS'
STAFF & PATIENT ENGAGEMENT COMMITTEE
PROPOSED TERMS OF REFERENCE**

Constitution

The Staff and Patient Engagement Committee is a committee of the Council of Governors. It has no delegated power to make decisions on behalf of the Council.

Purpose:

The Committee is responsible to the Council of Governors for the following:

- Identify priorities for Council debate and engagement and make recommendations to the Council for its future agendas.
- At each meeting, consider:
 - issues of Quality raised by Governors or their constituents to identify trends and themes;
 - the Board assurance framework; and
 - quarterly performance against the annual quality objectives and identified risk.

Use this information to inform the development of a draft of the Council commentary on the Trust's Quality report to take to Council for agreement.

- Propose to Council a topic for the Governor Indicator for audit by external auditors.

Frequency of Meetings:

Meetings of the Committee will be held quarterly.

Membership and attendance:

The Committee will consist of eight Governor members appointed every May for a one year period. Membership will be voluntary and based on skills and interest. Committee members will agree the Chairmanship of the Committee each year at their first meeting after appointment.

All governors will have the right to attend Committee meetings and participate in discussions. Only members of the Committee will have voting rights.

Quorum:

The Committee shall be quorate when at least four members are present. Virtual attendance at meetings is accepted.

Support:

The committee will be supported administratively by the Corporate Secretariat and receive professional advice from the Group Company Secretary.

DRAFT

**COUNCIL OF GOVERNORS'
AUDIT AND GOVERNANCE COMMITTEE
PROPOSED TERMS OF REFERENCE**

Constitution

The Audit and Governance Committee is a committee of the Council of Governors. It has no delegated power to make decisions on behalf of the Council.

Purpose:

The Committee is responsible to the Council of Governors for the following:

- Working with the Board of Directors' Integrated Audit and Governance Committee (IAGC) to establish the criteria for the appointment, re-appointment or removal of the Trust's external auditors, including the method for monitoring the quality of the external audit as set out in HEFMA NHS Audit Committee Handbook.
- Presenting to the Council of Governors the procurement process that it has followed for the appointment of the external auditors, the results of the procurement processes and recommendations.
- Receiving the external auditor's plan and work timetable for the year, to review the external auditor's performance and review any year end audit recommendations.
- Receiving the internal auditors plan, work timetable and annual report, for information only.
- Seek assurance from the Chair of the IAGC that internal control processes are in place and working effectively.
- Working with the Trust Secretary to ensure the Trust's Constitution complies with latest legislation and NHS I guidance.
- Considering any locally proposed amendments to the EKHUFT Constitution.
- Reviewing the effectiveness of NED engagement with Council Committees and Working Groups and report conclusions to the Council.
- Consider proposals for changes to policies relating to the Council of Governors and make recommendations to Council.

Frequency of Meetings:

Meetings of the Committee will be held quarterly.

Membership and attendance:

The Committee will consist of eight Governor members appointed every May for a one year period. Membership will be voluntary and based on skills and interest. Committee members will agree the Chairmanship of the Committee each year at their first meeting after appointment. All governors will have the right to attend Committee meetings and participate in discussions. Only members of the Committee will have voting rights.

Quorum:

The Committee shall be quorate when at least four members are present. Virtual attendance at meetings is accepted.

Support:

The committee will be supported administratively by the Corporate Secretariat and receive professional advice from the Group Company Secretary.

DRAFT

	April	May	June	July	August	Sept	October	November	December	January	February	March
CoG COMMITTEES ANNUAL CYCLE												
MECC NRC One annual meeting and then as required for NED appointments	To R ToR NED rem & appraisal Board skill review			AMM prep			x			x		
Staff & Patient Experience Committee	ToR NED rem & appraisal Board skill review			x			x			x		
Audit and Governance	ToR			x			x			x		
COUNCIL ANNUAL CYCLE												
	Briefing Meeting	Public & closed	Briefing Meeting	Briefing meeting & Training day	Public & closed	Briefing meeting & AMM	Briefing Meeting	Public & closed	Briefing Meeting	Briefing Meeting & Strategy session	Public & closed Joint with NEDs pm	Briefing Meeting
	One hour	Half day	One hour	One hour half day	Half day	One Hour Evening	One hour	Half day	One hour	One hour half day	Full day	One hour
Chair Report		P & C			P & C			P & C			P & C	
CEO report		P & C			P & C			P & C			P & C	
Council Committee reports		P			P			P			P	
NED overview report		P			P			P			P	
Record any virtual decision since last meeting		P			P			P			P	
Joint site visit action log		C			P			P			P	
Appraisal: Chair		C			if new Chair			if new Chair			agree process - C	
Appraisal: NEDs		C			if new NEDs			if new NEDs			agree process - C	
Governance documents :												
Quality Report commentary		ratify								agree process & indicator		draft virtually via WGrp
Annual report		C - in draft			Ext Aud attend	Present						
Annual Accounts		C - in draft			Ext Aud attend	Present						
Self certification agsinst Provider Licence		P										
Annual Governance Statement		P									xAGC rep	
IAGC report - performance of External Auditors		x										
Council and committees effectiveness		C							prepare	issue survey	C	
Governance items												
Register of interests - annual		P										
Annual F&PP declaration renewal		P										
Committee terms of reference		P										
Lead Governor elections		P										
Staff Survey					P							
Annual Members meeting					P							
Committee membership		P										virtual
Annual meeting dates								P				
Report on visits		P			P			P			P	
NON ANNUAL CYCLE												
Constitution review ***						2018						
Policies/Guidance												
Governor Code of Conduct												
Travel & expenses												
Appraisal Chair												
Appraisal NED												
Dispute resolution												
MEC strategy												
Managing allegations of breach												
Auditors appointment		1st cycle 19/20, 3 year contract, can extend - review end 2021										
Significant Transactions, mergers, acquisitions etc.		As required										
Taking decisions on non-NHS income		As required										

Governor Finance Briefing

20th May 2021

Philip Cave

Director of Finance and
Performance Management



Agenda

1. 2020/21 Financial Position
2. Planning Priorities
3. Financial planning in 2021/22
4. Next Steps

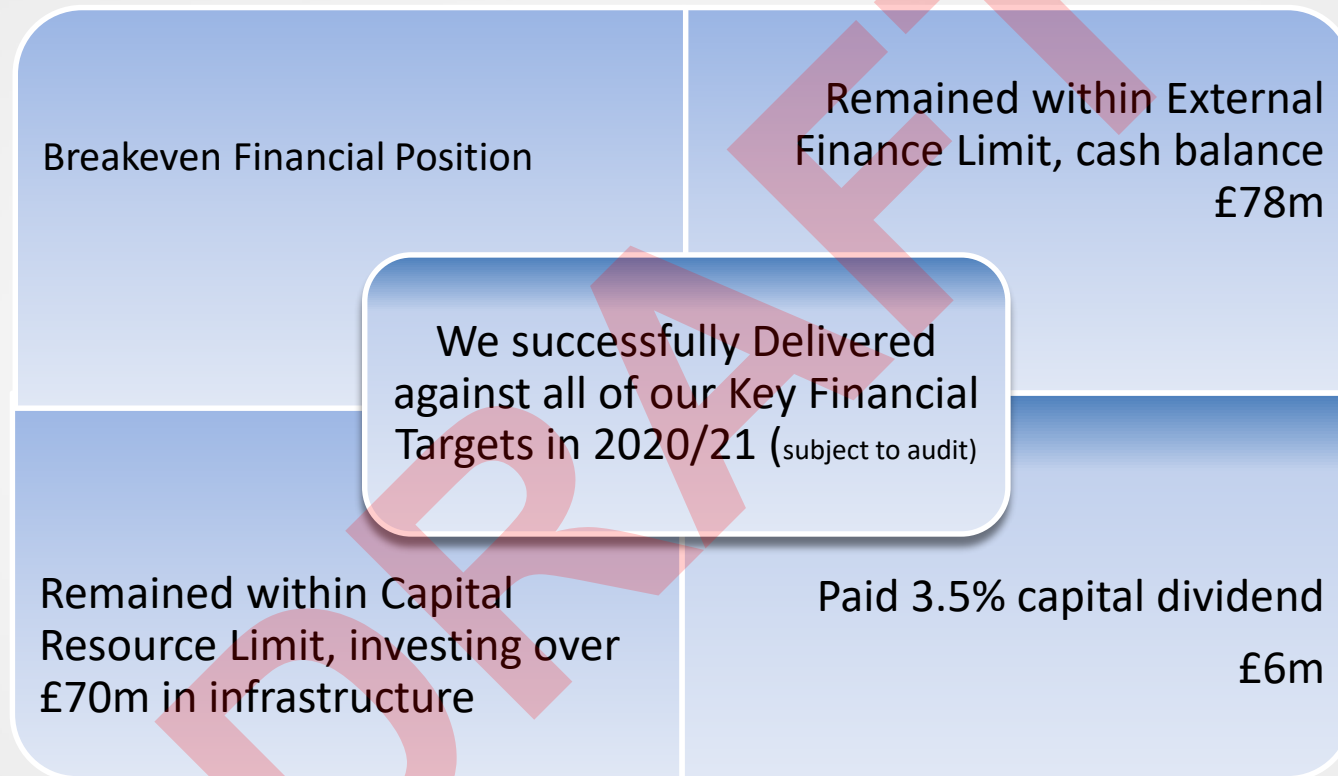


Agenda

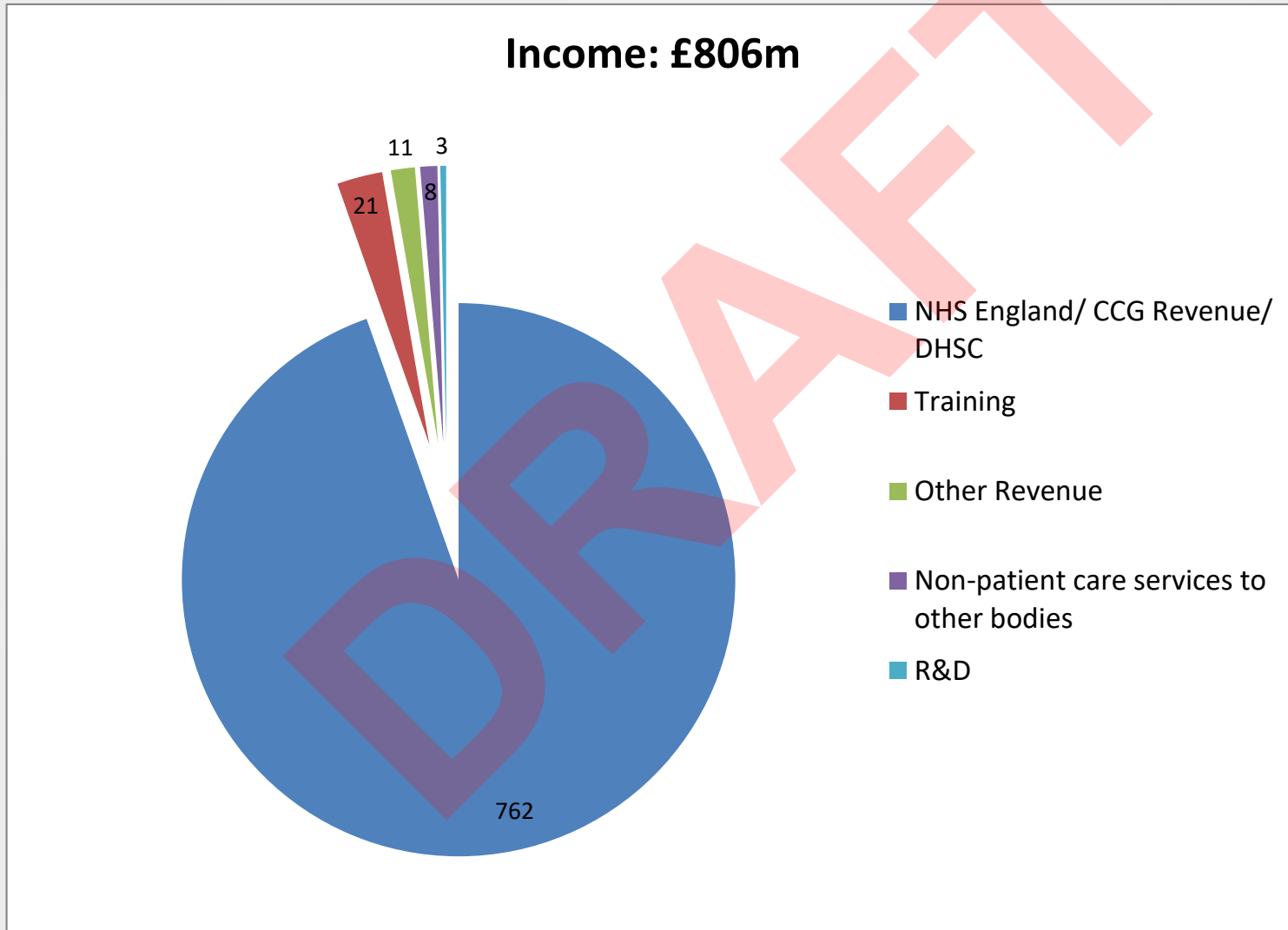
1. 2020/21 Financial Position
2. Planning Priorities
3. Financial planning in 2021/22
4. Next Steps



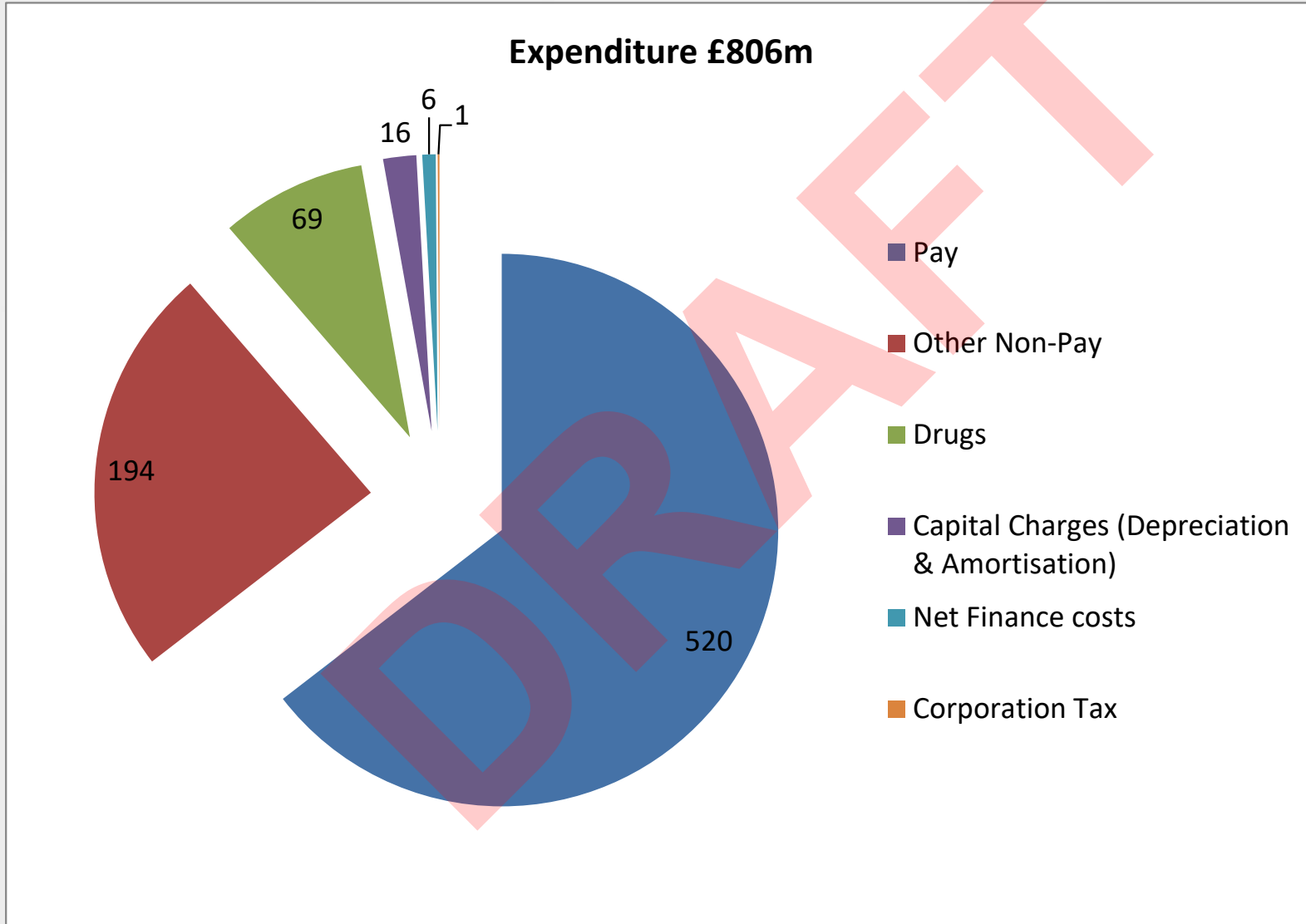
Performance against targets



Income: £806m



Expenditure: £806m



Capital: £70+m

CAPITAL SCHEMES 2020/21	20/21 CAPITAL SPEND £'000
ITU Expansion WHH - New build	13,492
Elective Orthopaedics Centre	10,115
ED Expansion	6,509
COVID-19 - Estates & equipment	5,564
Grants/ Donated assets (inc ventilators from NHSE/I)	4,996
IT/ Systems replacement (inc EMR/ T3 system, LIMs hardware, KMCR, ITU System)	4,854
Energy Performance contract (EPC)	4,668
Backlog maintenance/ patient environment (PEIC)	4,391
Medical Equipment replacement (MDG)	2,880
Radiology equipment (x-ray)	1,875
Vascular - New IR room K&C/ EVT replacement	1,608
COVID-19 - 8 bed ITU WHH	1,490
Da Vinci Robot - replacement	1,402
Installation of MRI QEQM	1,006
Breast Screening replacement vans/ kit (Mammography)	974
Endoscopy decontamination	924
Subsidiaries (2gether and SPH)	902
Installation of CT K&C	665
Cardiac Catheter lab replacement	591
PY Schemes - Prior year schemes deferrals/ VAT reclaim	495
Static Mammography kit x 2 rooms K&C	456
Replacement of Gamma cameras (CT SPECT)	417
Mobile x-ray & Ultrasound machines	408
TOTAL CAPITAL SPEND	70,682



Agenda

1. 2020/21 Financial Position
2. Planning Priorities
3. Financial planning in 2021/22
4. Next Steps



2021/22 Planning Summary

- Business Planning is a lot later to start this year because of the Covid pandemic. Guidance has only been released for a 6 month period (April to September 2021).
- Business planning is being managed at an Integrated Care System (ICS) level (Kent and Medway) with an overall aim to breakeven for that period whilst recover elective activity back to 85% of 2019/20 levels.
- The Trust is actively engaged with the system to deliver:
 - Recovery of elective activity as described.
 - Breakeven financial plan for the first 6 months of the year.
 - Key national and local priorities.
- The Trust is working with care groups and corporate teams to ensure there is a robust half year and full year plan.
- The financial breakeven of the Trust is dependent on the following:
 - Reducing the Covid spend run rate
 - Delivering a small CIP
 - Delivering increased elective work



National Key Planning Priorities

1. Looking after our people and helping them to recover.
2. Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19.
3. Accelerate the restoration of elective and cancer care and managing the increasing demand on mental health services.
4. Expanding primary care capacity to improve access, local health outcomes and address health inequalities.
5. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments, improve timely admission to hospital for ED patients and reduce length of stay.
6. Working collaboratively across systems to deliver on these projects.



East Kent Key Planning Priorities

1. We Care Priorities (True Norths)
2. Develop a Trust Group integrated Workforce Plan in response to the Covid pandemic and recovery programme.
3. Ensuring ICS and ICP are considered as part of business planning.
4. Estates strategy - medium term estate strategy.
5. Digital - ensure reduce footfall to the Trust.
6. A review of our Group structure.
7. Develop a Specialty level bed model for Winter 2021 including service changes in Elective Orthopaedics and Vascular/ Interventional Radiology services.



Agenda

1. 2020/21 Financial Position
2. Planning Priorities
3. Financial planning in 2021/22
4. Next Steps



Key 2021/22 Financial Principles

Recover Activity to 85% 2019/20
Levels with Elective Recovery Fund

Reduce Covid Spend and start
to introduce efficiencies

Breakeven Financial Plan (1st
6 months of year)

Capital Plan of over £40m,
including £23m A&Es

Income set at block payment
Managing Financial Risk
through the ICS



Agenda

1. 2020/21 Financial Position
2. Planning Priorities
3. Financial planning in 2021/22
4. Next Steps



2021/22 Planning process H1

Key submission dates

- **Half Year I&E Plan**
 - FPC - 27th April 2021
 - Trust Board - 29th April 2021
 - System financial plan - 6th May 2021
 - Provider plan submission - 24th May 2021
 - FPC Plan 25th May 2021
 - Trust Board 27th May 2021
 - Final system plan submission – 3rd June 2021

DRAFT



Integrated Performance Report

March 2021



Our vision, mission and values

'We care' is how we're working to give great care to every patient, every day. It's about being clear about what we want to focus on and why and supporting staff to make real improvements, by training and coaching everyone to use one standard method to make positive changes.

We know that frontline staff are best placed to know what needs to change. We've seen real success through initiatives like 'Listening into Action', 'We said, we did', and 'I can'.

'We care' is a bigger version of this – it's the new philosophy and new way of working for East Kent Hospitals. It's about empowering frontline staff to lead improvements day-to-day.

It's a key part of our improvement journey – it's how we're going to achieve our vision of great healthcare from great people for every patient, every time.

For 'We care' to be effective, we need to be clear about what we are going to focus on – too many projects will dilute our efforts.

For the next five years, our strategic focus centres on five themes:

- our **patients**
- our **people**
- our **future**
- our **sustainability**
- our **quality and safety**



What is the Integrated Performance Report (IPR)?

To turn these strategic themes into real improvements, we're focusing on five key objectives that contribute to these themes for the next year.

- Reducing falls
- Reducing healthcare acquired infections
- Reducing deaths from sepsis
- Improving theatre capacity
- Reducing patient time in ED once there has been a decision to admit.

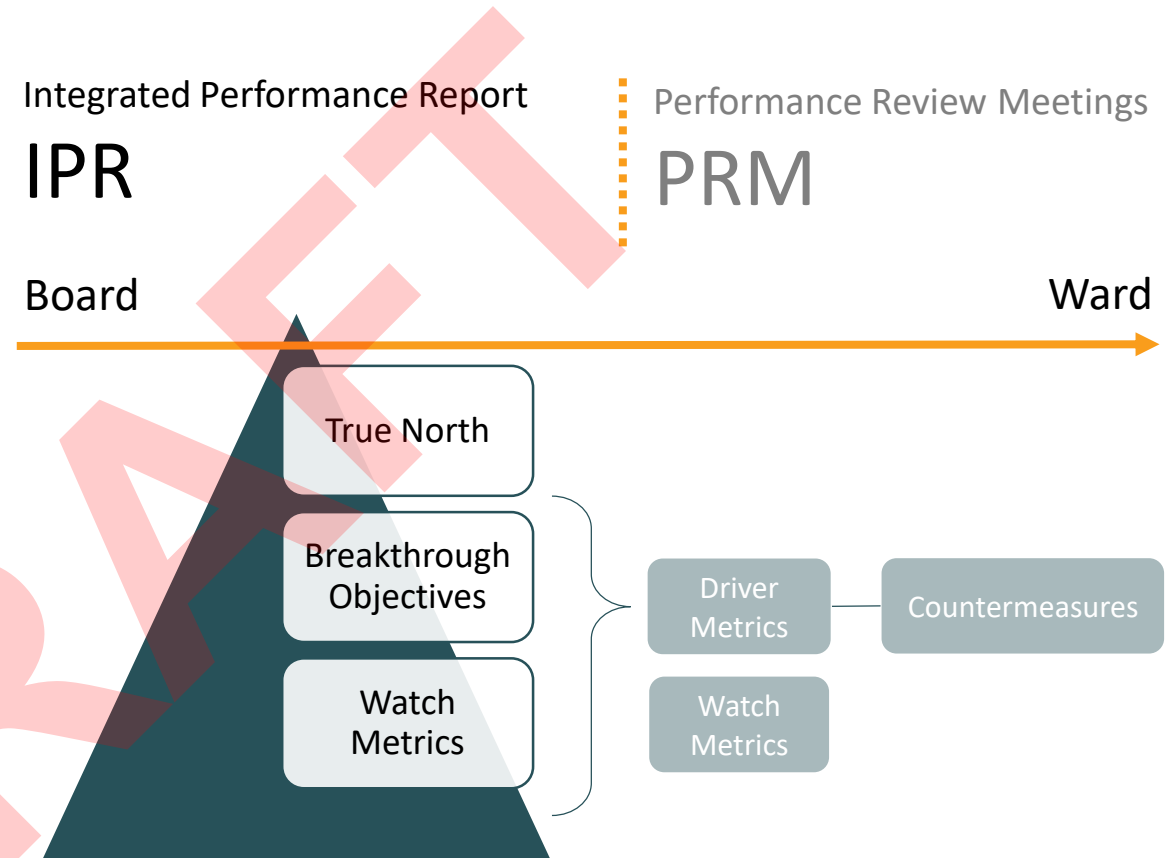
We have chosen these five objectives using data to see where we can make the most significant improvements by focusing our efforts. We'll also use data to measure how much we're making a difference.

Frontline teams will lead improvements in these areas of focus. They will be supported by our Improvement Office, which will help give teams the training and tools they need, and our Executive Directors will set the priorities and coach leaders in how to support change. Our corporate teams will work with frontline teams to tackle organisation-wide improvements.

We recognise that this change in the way we work together means changing our behaviour and the way we do things. We will develop all leaders – from executive directors to ward managers - to be coaches, not 'fixers'. We will live our Trust values in the way we work together, and involve patients in our improvement journey.

Integrated Performance Report IPR

Board



Ward

The IPR forms the summary view of Organisational Performance against these five overarching themes and the five objectives we have chosen to focus on in 2020/21. It is a blended approach of business rules and statistical tests to ensure key indicators known as driver and watch metrics, continue to be appropriately monitored.

What is statistical process control (SPC)?

Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in doing so, guides us to take the most appropriate action.

The 'We Care' methodology incorporates the use of SPC Charts alongside the use of Business Rules to identify common cause and special cause variations and uses **NHS Improvement SPC icons** to provide an aggregated view of how each KPI is performing with statistical rigor.

The main aims of using statistical process control charts is to understand what is different and what is normal, to be able to determine where work needs to be concentrated to make a change. The charts also allow us to monitor whether metrics are improving.

Key Facts about an SPC Chart

A minimum of 15-20 data points are needed for a statistical process control chart to have meaningful insight. 99% of all data will fall between the lower and upper confidence levels.

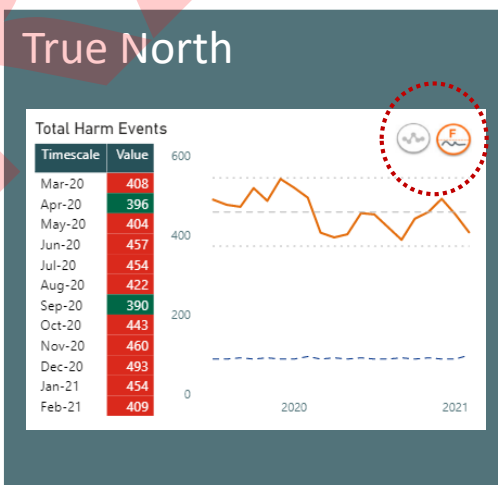
If data point falls outside these levels, an investigation would be triggered.

It contains two types of trend variation: Special Cause (**Concerns** or **Improvement**) and **Common Cause** (i.e. no significant change).

NHS Improvement SPC icons

Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Where to find them



What are the Business Rules?

Business rules work in conjunction with SPC alerts to provide a prompt to take a specific action.

This approach allows the organisation to take a measured response to natural variation and aims to avoid investigation into every metric every month, supporting the inch wide mile deep philosophy.

The IPR will provide a summary view across all True North metrics, detailed performance, actions and risks for Breakthrough Objectives (driver) and a summary explanation for any alerting watch metrics using the business rules as shown here as a trigger.

#	Rule	Suggested rule
1	Driver is green for reporting period	Share success and move on
2	Driver is green for six reporting periods	Discussion: 1. Switch to watch metric 2. Increase target
3	Driver is red for 1 reporting periods (e.g. 1 month)	Share top contributing reason, and the amount this contributor impacts the metric
4	Driver is red for 2 reporting periods	Produce Countermeasure summary
5	Watch is red for 4 months	Discussion: 1. Switch to driver metric (replace driver metric into watch metric) 2. Reduce threshold
6	Watch is out of control limit for 1 month	Share top contributing reason (e.g. special / significant event)

Our Quality & Safety



Siobhan
Jordan



Rebecca
Martin

Incidents Potentially Contributing to Harm

The True North target is to achieve zero avoidable harm within 5-10 years. Our calculation includes incidents with harm or those that have the potential to lead to harm and aggregates the following;

- Falls
- Pressure Ulcers
- C Difficile (in-hospital)
- E.Coli (in-hospital)
- Covid Infections (in-hospital)
- Nutrition Incidents
- Medication Errors

The effects of patient safety incidents go beyond the impact of the physical injury itself. Patients and their families can feel let down by those they trusted, and the incident may also lead to further unnecessary pain and additional therapy, or operative procedures and additional time in hospital or under community care.

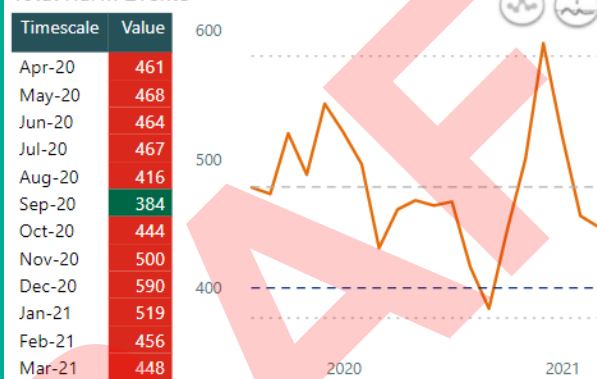
Mortality (HSMR)

Mortality metrics are complex but monitored and reported nationally as one of many quality indicators of hospital performance. While they should not be taken in isolation they can be a signal that attention is needed for some areas of care and this can be used to focus improvement in patient pathways.

Our aim is to reduce mortality and be in the top 10% of all Trusts for the lowest mortality rates in 5 to 10 years.

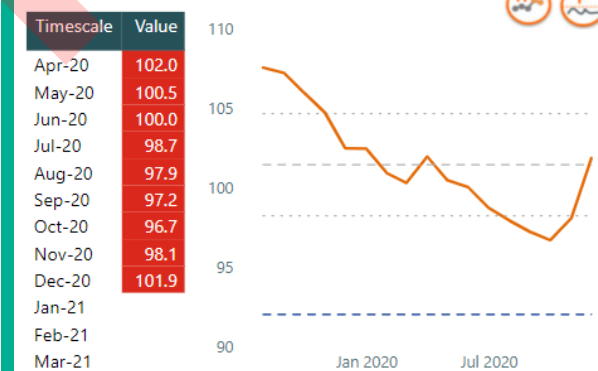
Incidents Potentially Contributing to Harm
To achieve and sustain zero avoidable harm.

Total Harm Events



Hospital Standardised Mortality Ratio (HSMR)
To reduce our Hospital Standardised Mortality Ratio and be in the top 10% of all Trusts.

HSMR



Our Patients



Rebecca Carlton

Trust Access Standards (Cancer, RTT & ED)
It is poor patient experience to wait longer than necessary for treatment and failure against these key performance standards is a clinical, financial and regulatory risk for the Trust.

The Trust has struggled to achieve consistently the national access standards for ED, RTT and Cancer, for a number of years. It is therefore important that these form a key part of our True North strategy for the coming years.

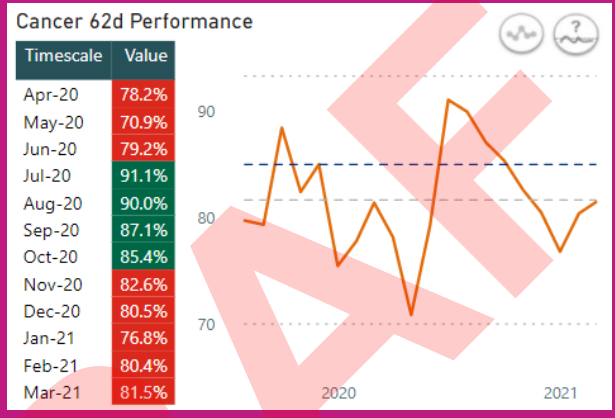


Siobhan Jordan

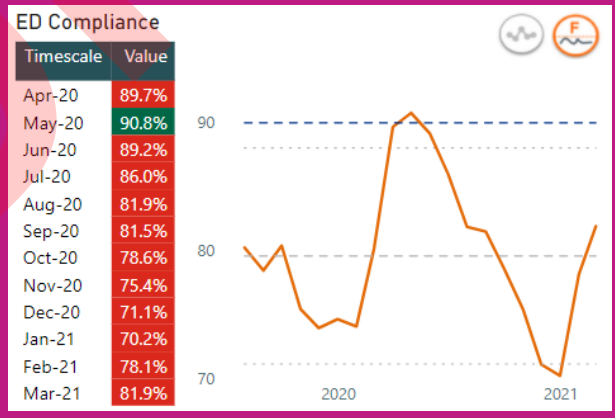
Patient Experience (FFT)
The Family and Friends Test is a national measure which confirms how likely patients are to recommend the Trust as a place for treatment. This data collection incorporates a scale for quantitative analysis and an area for free text comments and is gathered on a monthly basis.

The FFT is mandated across all acute providers and therefore provides an opportunity to benchmark across the country. It is important to consider the proportion of patients completing the test and the overall recommended score together, we have therefore added completion rates as watch metrics to our overall scorecard.

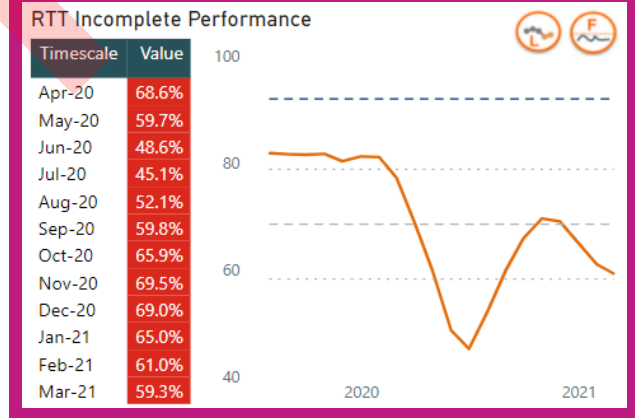
Cancer 62 Day
To achieve and sustain 85% performance for patients on a Cancer pathway.



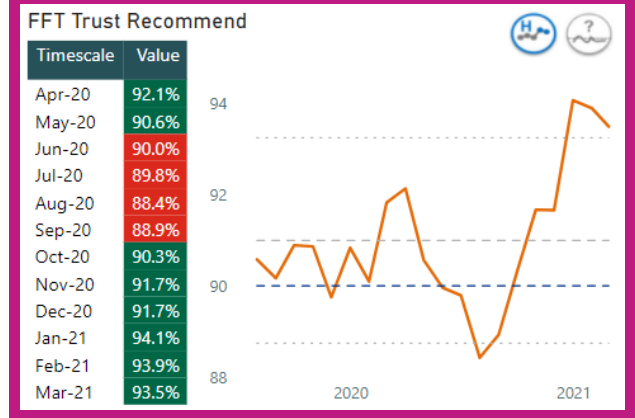
ED 4 Hour Compliance
To achieve and sustain 95% of all patients attending ED receiving treatment or admission with 4 hours.



RTT: 18 Week Compliance
To achieve and sustain 92% of all patients waiting less than 18 weeks for first definitive treatment.



Patient Experience (Friends & Family Test)
To achieve consistent recommendation rates in excess of 90% from patient friends and family.



Our People



Andrea Ashman

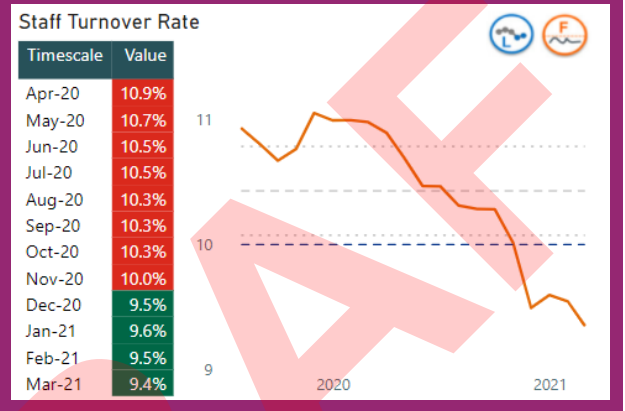
Staff Turnover (rate) The annual turnover rate provides us with a high-level overview of Trust health.

Workforce retention is a top priority across the NHS. High turnover rates are typically associated with increased recruitment and training costs, low morale and reduced performance levels.

Staff Engagement (score) Staff satisfaction levels are amongst the bottom 20% across the country, which can lead to difficulty in recruitment and retention.

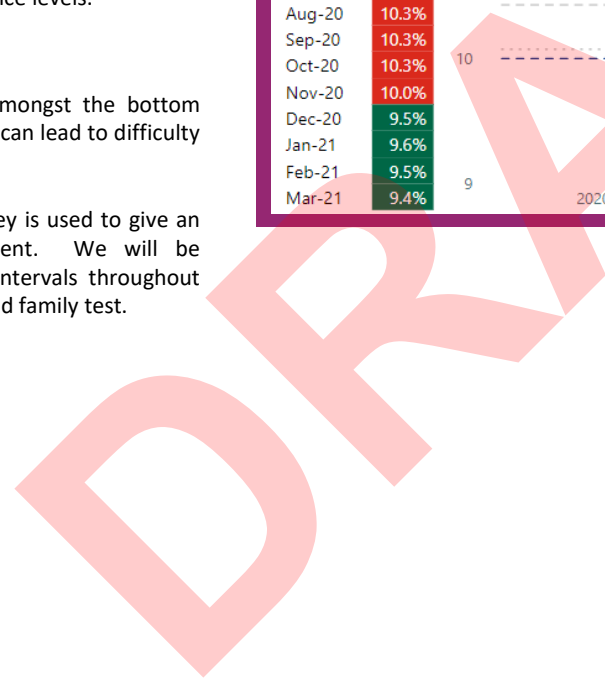
The annual national staff survey is used to give an indication of staff engagement. We will be monitoring this at quarterly intervals throughout the year via the staff friends and family test.

Staff Turnover To achieve and maintain a 10% staff turnover rate.



Staff Engagement To improve our staff engagement score as demonstrated in the annual staff survey.

Data not yet available



Our Sustainability



Phil Cave

Financial Position (I&E Margin)

Whilst there has been a significant financial deficit over the last 3 years at the Trust, in the current year a breakeven position was delivered. This metric will measure us against our long terms aim to maintain remain with a breakeven position.

The impact of Covid-19 has paused the NHS business planning process nationally and has limited the ability of the Trust to hit its cost efficiency targets.



Liz Shutler

Carbon Footprint (CO2e)

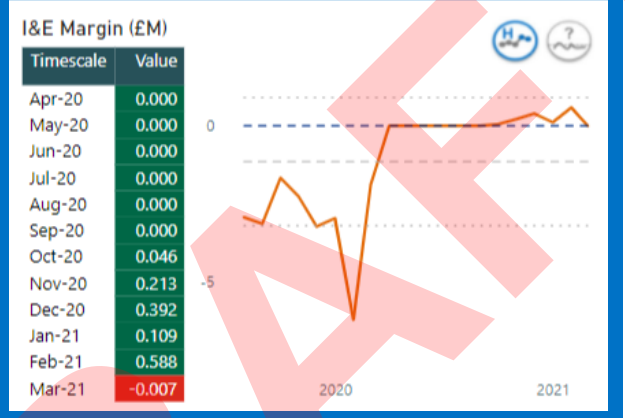
Being environmentally sustainable is a key element of our Trust; True North.

Implementing environmentally sustainable principles and reducing our greenhouse gas emissions, adds value to our patients and reflects the ethics of our staff.

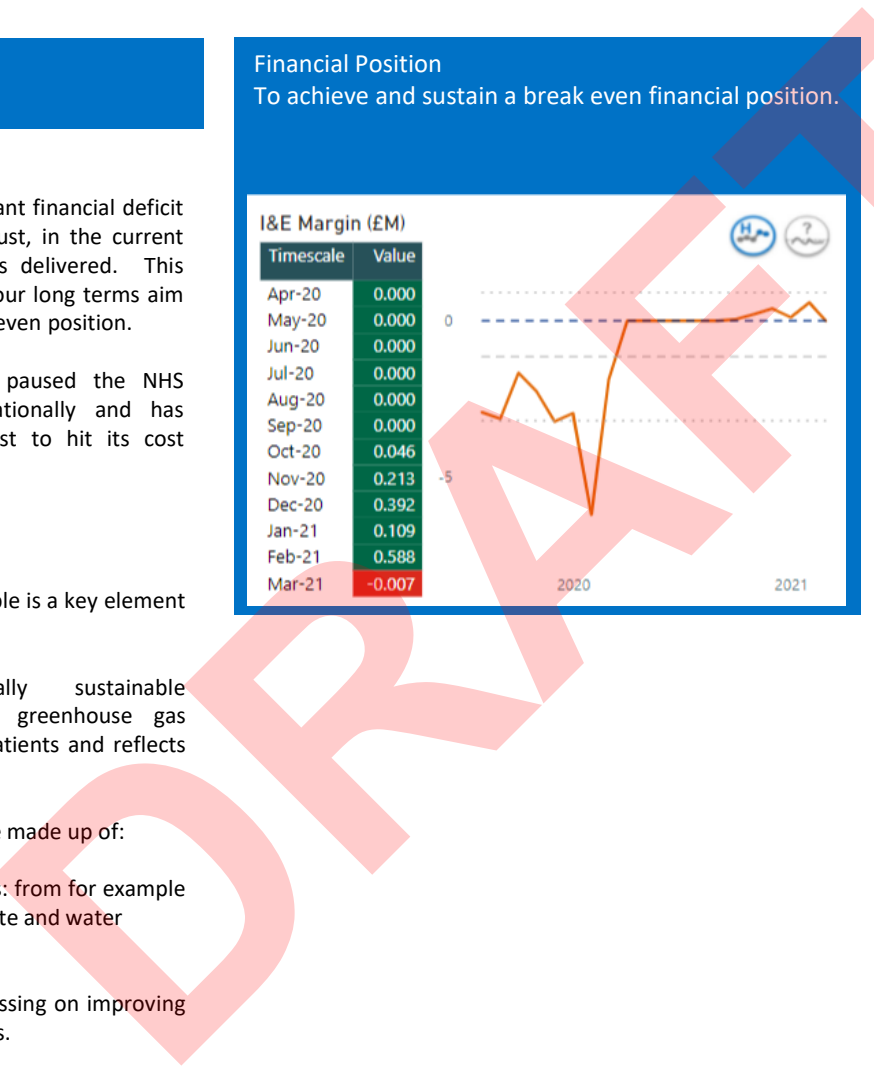
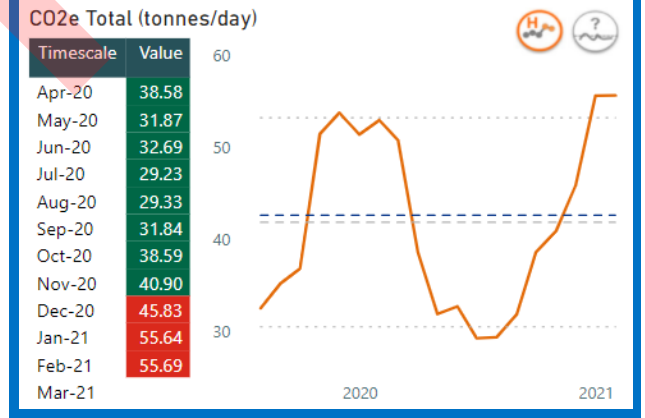
- The Trust's carbon emissions are made up of:
- Direct emissions: natural gas
 - Indirect and direct emissions: from for example electricity consumption, waste and water
 - Waste

It is these areas we will be focussing on improving over the coming five to ten years.

Financial Position To achieve and sustain a break even financial position.



Carbon Footprint To achieve an organisational carbon neutral footprint.



Our Future



Liz
Shutler

Medically Fit for Discharge

Across the Trust, patients are deemed as 'ready' and 'medically fit for discharge' but continue to remain under our acute care.

Unnecessary bed stays can negatively affect patient experience. In addition prolonged stays in hospital (especially for those who are frail or elderly) can lead to an increased risk of falling, sleep deprivation, catching infections and sometimes mental and physical deconditioning.

By working with our partners in the wider health & social care community to ensure patients return to their usual place of residence, or other care setting, as soon as it is safe to do so patient flow will improve through the system. This metric was chosen as it represents the system working in an integrated way. As the system matures this metric may change to 'criteria to reside'.

Innovation (Virtual OP Apps)

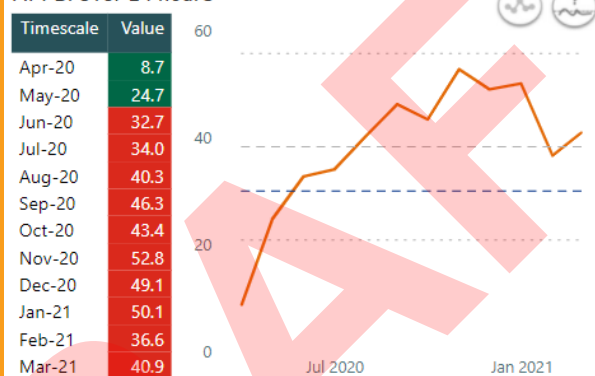
The current process for achieving innovation at the Trust is cumbersome and timely. A cultural shift needs to take place using IT as a key enabler to drive the process.

Outpatients are working towards the targets set by our commissioners of at least 25% of all patient appointments and 60% of all follow ups to be conducted via telemedicine and to that end we have developed an enhanced engagement plan to meet this target and also to encourage the shift to Web from phone where possible. We have also set a stretch target of 80% to drive innovation in this area.

Medically Fit for Discharge

To ensure patients are cared for in the appropriate setting in a timely manner.

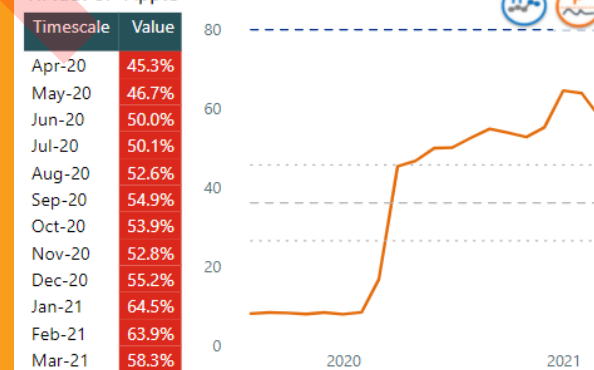
MFFD: Over 24 hours



Innovation

To increase the use of technology and innovation in the delivery of high quality care for the East Kent population.

Virtual OP Appts

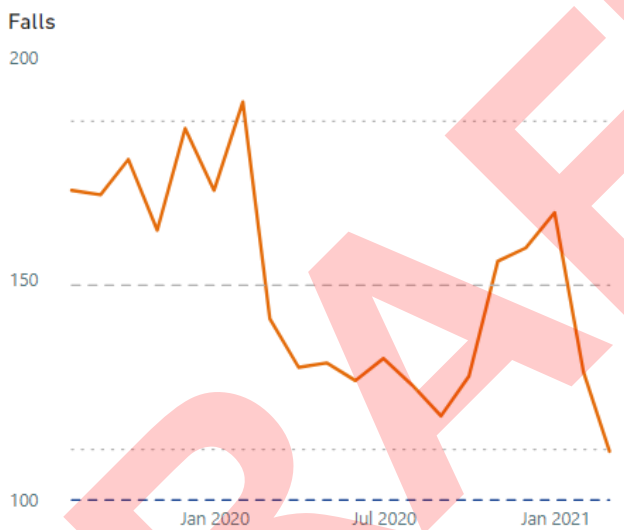


2020/21 Breakthrough Objectives

Falls

Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
130	131	127	132	126	119	128	154	157	165	129	111

Domain	Our Quality & Safety
True North	Harm Events
Metric Focus	Driver
Threshold	100
Value	Number
Improvement Direction	Lower is Better



- D2** Driver is red for 2
- L** Special cause of improving nature or lower pressure due to lower values
- F** Variation indicates consistently falling short of the target

Understand the data
 Total number of recorded falls. Assisted falls and rolls are excluded.
 Data source - Datix

We are driving this measure because...

The Quality & Safety True North target is to achieve zero avoidable harm within 5-10 years. Our analysis shows that currently falls are the greatest contributor (40%) to harm events. Currently 45% of falls are reported as not resulting in harm and 54% of falls are reported as resulting in low harm. The assessment of falls is not currently standardised across the Trust.

Any fall can leave patients and their families feeling let down by those they trusted, with the potential need for further therapy, pain, operative procedures or additional time under community care or in hospital. All can impact long term outcome.

Performance

Current Performance is 111 falls recorded in March 2021. This number has been trending negatively for the last three months representing an improving picture.

Our investigations into this breakthrough objective demonstrate that 13 wards across the Trust contribute to 94% of all falls. Reasons attributed to falls are varied however the single highest number recorded are 'unwitnessed – found on floor'. Root cause analysis so far suggests there is a lack of clarity of the outcome of the fall and in some cases the cause.

In order to reduce the number of falls the first wave of frontline 'We Care' teams have carried out root cause analysis on their own ward based data and developed A3's detailing improvement projects bespoke to their findings. The falls steering group have investigated the root cause of unwitnessed falls and suggested potential improvements. The Trust Priority Improvement Project (TPIP) has provided an interim solution for the accurate recording of harm as a result of a Fall, pending the national Datix upgrade in the Autumn.

Risks

Risk of barriers with communication between frontline teams regarding A3 progress. To mitigating against this, we have invited the Ward Managers to join our weekly Driver meetings and share their improvements.

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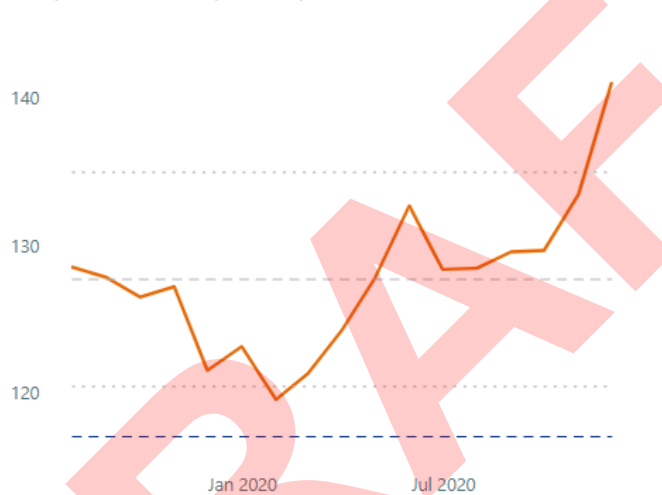
2020/21 Breakthrough Objectives

Composite HSMR: Sepsis/Resp

Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
124.3	127.8	132.7	128.4	128.4	129.6	129.7	133.5	141.0			

Domain	Our Quality & Safety
True North	Mortality
Metric Focus	Driver
Threshold	117.0
Value	Number
Improvement Direction	Lower is Better

Composite HSMR: Sepsis/Resp



Driver is red for 2



Special cause of concerning nature or higher pressure due to higher values



Variation indicates consistently falling short of the target

Understand the data

The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality comparing a Trust's actual number of deaths to its expected/predicted number of deaths. This Composite HSMR metric is a subset of HSMR and only accounts for two of the 56 diagnosis groups: "Septicemia (except in labour)" and "Respiratory failure, insufficiency, arrest (adult)".

If a Trust has an HSMR of 100, this means that the number of patients who died is exactly as would be expected. Values above 100, suggest a higher than expected mortality and those below as within an acceptable range. HSMR is an important indicator that acts as a smoke signal for potential problems with the quality of care. The figures represent a 12-month rolling position.

We are driving this measure because....

Sepsis and respiratory failure have consistently triggered as primary diagnostic categories making the greatest contribution to the Trust's HSMR over the last few years.

We believe that understanding and acting on the drivers behind this performance will help us provide a safer service for our patients.

Performance

Current performance shows a rolling 12-month composite Hospital Standardised Mortality Ratio (HSMR) for respiratory failure and sepsis of 141.0 for December 2020. This is driven by December 2020 in month HSMR which is significantly higher than expected and likely to be due to the pandemic second peak, similar to the pattern seen in April 2020.

- Key areas for focus to achieve the overall goal
- Recognition, escalation and response to patients deteriorating from sepsis and respiratory failure by clinical teams
 - Consistent response to deteriorating patients at night
 - Embedding learning from harm incidents

- Achievements over the last 30 days
- Established driver meetings for 7 frontline ward teams on 3 sites
 - Launch of Hospital out-of-hours team at acute sites in March 2021
 - Appointment of 3 Consultants to Learning from Deaths panel to focus on Structured Judgement Reviews (SJR) and Mortality and Morbidity (M&M) meetings

- Ambition for the next 30 days
- Agree Sepsis audit design with the Deteriorating Patient panel
 - Gap analysis of M&M meetings against Terms of Reference agreed in May 2021 to optimise learning from SJRs
 - Conference with BO frontline teams to share learning

Risks

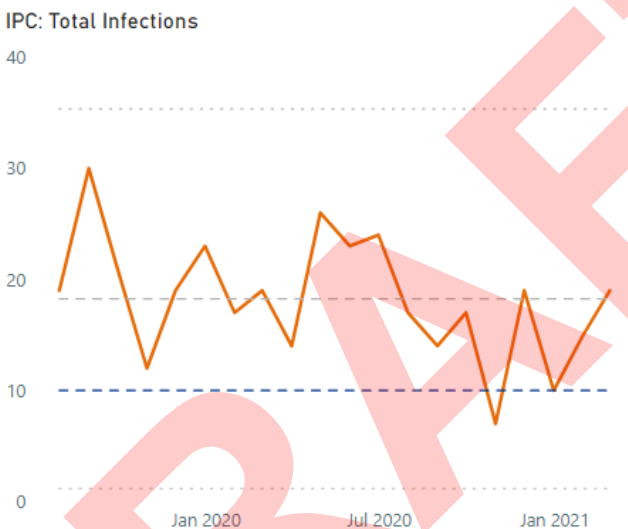
There are no identified risks to delivery of this breakthrough objective at this point.

Risks are identified and managed through weekly driver meetings and where needed escalated at We Care Executive Management meetings.

IPC: Total Infections

Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
14	26	23	24	17	14	17	7	19	10	15	19

Domain	Our Quality & Safety
True North	Harm Events
Metric Focus	Driver
Threshold	10
Value	Number
Improvement Direction	Lower is Better



- D2** Driver is red for 2
- Common cause (no significant change)
- Variation indicates inconsistently passing and falling short of the target

Understand the data

“Healthcare associated infection” (HCAI) also known “nosocomial” or “hospital” infection is an infection occurring in a patient during the process of care in a hospital or other health care facility which was not present of incubating at the time of admission. This aggregate measure will be updated to include a count of the number of MSSA*, C diff, MRSA, E coli*, Klebsiella species* (spp.) and Pseudomonas aeruginosa* cases.

*bloodstream infections only

We are driving this measure because....

Infection prevention control has been a focus of the organisation throughout 2020 and great strides have been made to improve performance across all sites.

It is important to continue the good work set in place during the global pandemic and apply learning to reduce all in hospital infections.

Performance

Current Performance for total in-hospital infections is 19 in March, driven largely by an in-month increase in C diff cases (12). This may be associated with the second wave of Covid driving antibiotic use. Performance has shown common cause variation over the last three months.

To improve our performance in this area we have, combined this information with the supporting metric data for Infection Prevention Practice Audits to identify the ten lowest scoring wards across the three sites. These wards are at the early stages of undertaking structured analysis at ward level to identify root causes and undertake PDSA cycles of improvement to sit alongside the improvements delivered through the integrated improvement plan. Some have begun Plan Do Study Act (PDSA) improvement work, some are yet to have their We Care training.

Additional countermeasures are focussed on reducing avoidable ward moves with a structured problem solving tool (A3) being developed with WHH Site team and reducing antimicrobial prescribing outside of guidelines (antimicrobial stewardship team having We Care training in April – A3 to be developed).

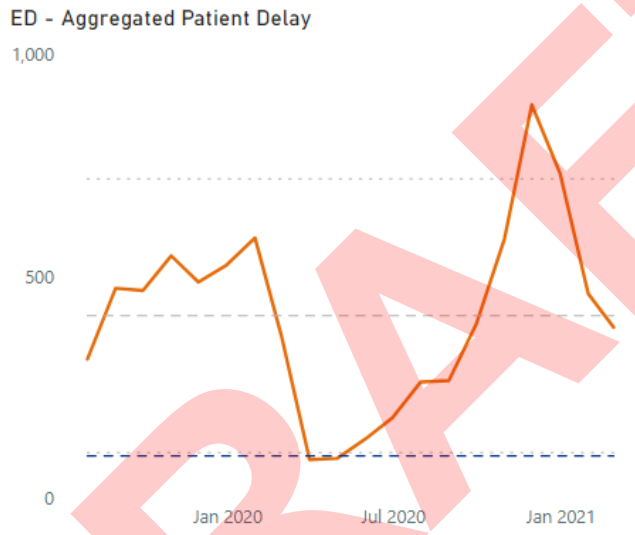
Risks

The Director of Infection Prevention and Control (DIPC) as Senior Responsible Officer (SRO) has reviewed the metric associated with this breakthrough objective and decided that it should include the other infections that are the subject of the national reduction ambition (Klebsiella species and Pseudomonas aeruginosa). This will require a recalculation of the threshold and performance which may cause some temporary uncertainty.

ED - Aggregated Patient Delay

Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
87	89	133	181	261	265	392	584	886	732	460	385

Domain	Our Patients
True North	ED Compliance
Metric Focus	Driver
Threshold	95
Value	Number
Improvement Direction	Lower is Better



- D2** Driver is red for 2
- Common cause (no significant change)
- F** Variation indicates consistently falling short of the target

Understand the data

A&E performance is directly dependent on the number and flexibility of available admitted beds, the aggregated patient delay measure counts the amount of time patients who breached the 4 hour standard spent in A&E awaiting admission to an Acute Medical Unit, Medical or Surgical Bed.

We are driving this measure because....

Long waits across our Emergency Departments have been a challenge to the organisation for several years, thought to be driven by a lack of access to inpatient beds. Recent improvements in bed availability have shown improvements in compliance. Consolidating and building on these improvements and improving timely care within ED will continue to improve patient care and the compliance against this metric.

We are making this an area of clinical and operational focus to drive down the wait times, improve flow and the standard of care for our patients.

Performance

Performance for March is an aggregated delay of 385 hours. Performance improvement of this metric is now in its third month running.

Key areas of focus for this breakthrough objective are;

- Emergency Portals
- Time in Hospital
- Discharge Process

Activities for the coming period include:

- focus on improving the accurate collection of criteria to reside data and how this can help timely discharge
- implementation of a new hospital discharge policy with a focus on early discharges
- a review of Urgent Treatment Centre (UTC) to reduce the number of patients in emergency department (ED) Majors
- Implementation of new Same Day Emergency Care (SDEC) pathways to reduce the number of admissions to ward beds and to reduce the number of patients in ED majors
- A review of ED processes to ensure that patient care is delivered in a timely and safe way at all times.
- QEQM Safer, Calmer Care event and opening of the Frailty Unit

Risks

Further work required to remove obstacles to enable expansion of SDEC, this will create more space and reduce the risk of over crowding.

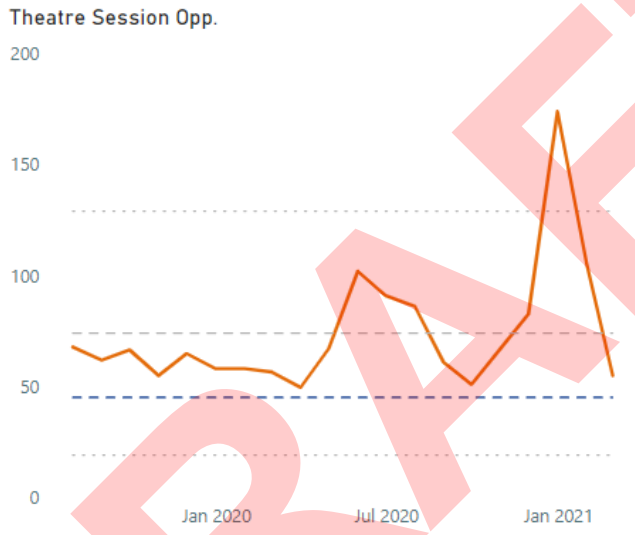
Engagement with specialty teams to reduce the risk of delays in the ward discharge process and delays in ED to access a bed.

Revision of care group metrics to improve engagement with staff on improvement objectives support ED performance.

Theatre Session Opp.

Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
50	67	102	91	86	61	51	67	83	174	106	55

Domain	Our Patients
True North	RTT - 18 Weeks
Metric Focus	Driver
Threshold	45
Value	Number
Improvement Direction	Lower is Better



- D2** Driver is red for 2
- Common cause (no significant change)
- Variation indicates inconsistently passing and falling short of the target

Understand the data

Total excess minutes (represented as 4 hr theatre lists) associated with specified non operative events during scheduled theatre time.

Non Operative Events (Cancelled Sessions, Turn Around Times Exceeding 10 Minutes, On The Day Cancellations, Early Finishes Exceeding 45 Minutes, Late Starts Exceeding 15 Minutes)

Exclusions (Emergency Lists, Non Bookable Lists (e.g. Trauma), Sessions Cancelled Due to Audit / Bank Holiday, Sessions Cancelled in Specialised Theatres (e.g. Ophthalmic Suite / Buckland), Sessions where Total available Opportunity <60 Minutes)

We are driving this measure because....

Efficient use of our theatre complex is key to maximising the throughput of routine elective care.

Emerging from the second wave of COVID-19 it is imperative that deferred elective surgery is prioritised alongside Cancer and urgent operative needs to minimise any harm to our patients and reduce our overall waiting times for elective surgery.

Ensuring that the theatre capacity we have available is utilised in the most efficient manner will allow for subsequent decisions regarding any residual capacity deficits and new ways of working.

Performance

Current Performance shows the equivalent of 55 sessions unused i.e. opportunity for March 2021. We have been displaying an improving performance for the last two months due to the national directive to recommence routine elective surgery, which is in line with our recovery plan. We are opening more theatres week on week in line with the recovery programme. Theatres continue to be allocated to the specialties delivering cancer and priority two (P2) surgery.

Our investigations so far have led to three areas of focus for the coming month, booking processes, in session utilisation and staff cover to run our theatres 50 weeks per year. There is a Trust Priority Improvement Project (TPIP) that will focus on the availability of theatre sessions vs job planned activity.

Actions for next period include review of booking processes to deliver six week advance booking of theatres as we move into our elective recovery programme (4R), Care Group root cause analysis on in session 'lost' time (e.g. late starts, early finished) and creation of a rota system to optimise respire allocation and booking. We will also review our pre operative assessment process to ensure patients are fit, ready and prepared for surgery.

Risks

3rd Wave of COVID could significantly impact on theatre utilisation if there is a directive to cease routine work.

Theatre staff recruitment has been challenging previously. This includes anaesthetic cover along with theatre personnel.

Alerting Watch Metrics: Our Quality & Safety

True North Domain	Type	BO	KPI	Thres.	Dec-20	Jan-21	Feb-21	Mar-21
Harm Events	W4		Covid-19 HCAI	1	179	112	95	53
	W4		MSSA Cases	1	6	3	3	3
	W4		Nutrition Incidents	20	15	13	20	31
	W4		Optimal Cord Clamping <32w	85.0%	0.0%	66.7%	72.7%	60.0%
Mortality	W4		Extended Perinatal Mortality	6.35	10.41	12.87	7.05	6.78

Performance

Harm Events

Between December and March we cared for 3,250 Covid-19 positive patients, a significantly higher number of patients compared to the first wave. The high number of patients needing hospital care reflected the extremely high rates of community infection and was contributed to by the second wave surge and Kent variant. Our rate of hospital acquired infection during this period was 13.32%.

The threshold for MSSA is being reviewed as part of the revision to the Total Infections Breakthrough Objective as detailed earlier in the pack.

The main contributing areas where incidents have been raised relating to nutrition during March are delays in nutrition provision and plans, issues relating to parenteral nutrition either due to split bags or incorrect prescriptions, Patients with dysphagia (swallowing difficulties) receiving incorrect texture meals or drinks. All of these incidents are shared at the Nutrition Steering and Oral Hydration Steering Group. Additional support will be provided to ward teams once the Nutrition and Hydration Nursing Team have been recruited.

The Women's Health Care Group has selected delayed cord clamping as one of their focused improvement projects recognising there has been inconsistent performance in this area. They have undertaken a structured analysis to identify the countermeasures that will have the greatest impact on performance. and are focussing on raising awareness and setting up a multi-professional working group to identify and address blockers to implementation.

Mortality

The extended perinatal mortality is a rolling 3 month average representing stillbirths and neonatal deaths using the MBRRACE criteria. The rolling average is falling and was affected by a higher than usual number of stillbirths in November and a smaller rise in January. We have undertaken a review including oversight of cases through the LMS to ensure we have captured all themes from learning into clinical pathways.



Alerting Watch Metrics: Our Patients

True North Domain	Type	BO	KPI	Thres.	Dec-20	Jan-21	Feb-21	Mar-21
Cancer 62d			Cancer 31d Performance	96.0%	100%	97.6%	98.4%	94.3%
			Radiology Diags vs Plan	Traj.	14,111	13,276	13,061	15,467
			Endoscopy vs Plan	Traj.	968	983	896	1,119
RTT - 18 Weeks			RTT 52w Breaches	2,586	2,544	3,613	4,632	5,232
			DM01 Compliance	99.0%	77.6%	64.7%	67.7%	73.6%
			RTT 35w Undated	8,500	7,128	7,088	7,523	8,122
			Referrals vs Plan	Traj.	18,311	17,315	18,393	22,089
			OPA vs Plan	Traj.	52,326	49,015	50,545	61,953
			Elective Admissions vs Plan	Traj.	3,770	3,164	3,146	4,223
			RTT 1st OPA Booking Breaches	14,000	11,634	12,331	12,346	12,888
ED Compliance			Clinical Assessment within 1hr	50.0%	39.7%	44.1%	42.5%	41.8%
			DTAs within 4hrs	600	700	777	1,137	1,326
			A&E Atts vs Plan	Traj.	16,148	13,905	14,136	13,680
			Unplanned Re-attendance ED	10.0%	10.5%	10.7%	10.5%	10.6%
			Super Stranded >21D	75	103	100	103	124
			NEL Admissions vs Plan	Traj.	5,143	4,873	5,251	6,517
FFT			FFT IP Response Rate	25.0%	15.8%	16.6%	16.0%	17.2%
			FFT ED Response Rate	12.0%	15.2%	14.6%	13.5%	14.2%
			FFT Maternity Response Rate	18.0%	5.7%	6.3%	5.5%	5.6%
			Mixed Sex Breaches	500	963			

Performance

Cancer 62 Day

31d cancer performance is alerting in March 21 due to a dip in performance below the lower confidence limit. This is down to the continued impact of the second wave of Covid-19 and we expect performance to return to a compliant position in April as we continue our theatre recovery programme.

Radiology and Endoscopy performance against plan is also linked to the second Covid-19 wave (plans set after wave 1) and operational teams are working through a detailed planning process in order to bring activity levels back up to 70% of pre-Covid levels in April 2021.

RTT 18 Weeks

All RTT measures are alerting due to the significant impact of the second Covid-19 wave on elective services. The Trust is focussed on rapidly increasing access to elective services in order and in line with the national elective recovery programme. The Trust has a positive OP and Endoscopy schedule which has helped reduce risk and ensure priority patients are supported.

ED Compliance

Work is underway with local system and regional partners to understand the increase in walk-in ED patients attending post lock down.

The unplanned reattendance rate is inflated due to planned returns not recorded accurately. Work has commenced to understand and improve data quality.

There is positive engagement with community colleagues to work closely to identify patients and address process delays impacting on discharge to community inpatient beds or services which aims to reduce the number of super stranded patients.

Friends & Family Test (FFT)

The Trust is working to improve FFT response rates across all settings and has observed a slight improvement across the board in March. Workstreams have been initiated to trouble shoot specific areas, particularly the low rates in Maternity. Whilst the ED response rate remains above the national average it was trending down below the mean which is causing the metric to alert.

Alerting Watch Metrics: Our People, Our Future & Our Sustainability

True North Domain	Type	BO	KPI	Thres.	Dec-20	Jan-21	Feb-21	Mar-21
Staff Engagement	W4		Appraisals Compliance	85.0%	70.2%	69.5%	68.8%	69.8%
	W4		Mandatory Training	93.0%	90.3%	90.3%	90.7%	91.1%
Financial Position	W4		Premium Pay	18.6%	16.9%	17.4%	17.5%	17.7%
	W4		Non Pay	0.0%	-2.8%	-3.2%	-3.1%	-11.3%
Carbon Footprint	W4		CO2e Gas (tonnes/day)	38.19	27.87	37.43	37.65	
Med. Fit for Disch.	W4		MFFD: Spot Purchase	5.0	17.3	19.3	12.1	11.3
	W4		MFFD: Community Hospital	5.0	8.0	7.6	5.9	10.1
	W4		MFFD: Home With Support	5.0	11.1	7.6	7.6	10.3

Performance

Staff Engagement

Appraisal compliance is steadily increasing now that there is more capacity away from the immediate pressures of the pandemic. This is an alerting watch metric if not a driver in all care groups and is being used to support individual plans for the year ahead. This should include wellbeing conversations and personal risk assessment reviews. Mandatory training is also improving as there is more capacity to plan training sessions with care groups having this as an alerting watch metric for review at monthly PRMS.

Financial Position

The financial position watch metrics are alerting because pay and non-pay are up on the expected position. This increase has been driven by the Covid-19 response costs and have therefore been funded centrally by the NHS. Overall for the financial year 21/22 the Trust has broken even (subject to external audit).

Carbon Footprint

Gas tonnage per day has breached the upper control limit in February 2021 and is therefore alerting this month. It is likely that usage will remain high into March due to seasonal variation and return back within the control limits as we move into the later part of spring.

Medically Fit for Discharge

The number of patients MFFD is alerting due to seven consecutive monthly data points above the threshold. This is being addressed and closely monitored through the 'Criteria to Reside' implementation to improve compliance throughout the Trust.



Appendix 1: Non-Alerting Watch Metrics

True North Domain	Type	BO	KPI	Thres.	Dec-20	Jan-21	Feb-21	Mar-21
Harm Events	w		52w Severe Harm Review	0	0	0	0	0
	w		MRSA Cases	1	0	0	1	0
	w		C Diff Cases	8	5	4	7	12
	w		E Coli Cases	10	8	3	4	4
	w		Medication Errors	90	56	54	62	57
	w		Pressure Ulcers: Grade 1 & 2	200	170	168	152	180
	w		Pressure Ulcers: Grade 3 & 4	40	26	25	19	30
	w		IPC: Audits Composite	80.0%	79.2%	86.4%	85.6%	87.5%
	w		VTE Assessment Compliance	90.0%	92.9%	93.4%	93.7%	93.9%
	w		Safeguarding Incidents	20	13	8	7	14
	w		IP Spells with 3+ Ward Moves	500	419	452	419	540
Cancer 62d	w		Cancer 2ww Performance	93.0%	97.6%	98.3%	98.1%	98.7%
	w		Cancer 28d Performance	75.0%	69.4%	59.4%	73.7%	79.3%
ED Compliance	w		ED Non-Admitted Compliance	90.0%	83.5%	84.7%	89.7%	91.2%
	w		Ref to Spec 2.5h	40.0%	81.1%	93.4%	91.0%	90.2%
	w		Discharges by Midday	15.0%	15.1%	13.9%	14.5%	14.0%
	w		NEL Readmissions	15.0%	11.8%	11.3%	10.7%	12.2%

Appendix 1: Non-Alerting Watch Metrics

True North Domain	Type	BO	KPI	Thres.	Dec-20	Jan-21	Feb-21	Mar-21
FFT	w		FFT DC Response Rate	30.0%	32.9%	37.1%	33.1%	33.9%
	w		FFT OP Response Rate	20.0%	19.1%	20.2%	19.4%	19.1%
	w		Complaints	100	55	60	60	65
	w		Complaint Responses <30 days	90.0%	73.7%	61.9%	100%	100%
	w		PALS Enquiries	550	572	493	447	596
Staff Turnover Rate	w		Vacancy Rate	9.0%	6.1%	6.6%	6.4%	6.3%
	w		Staff Turnover: HCA	13.5%	11.8%	10.9%	11.6%	11.1%
	w		Staff Turnover: Nursing	10.0%	10.0%	10.5%	10.6%	11.0%
	w		Premature Turnover Rate	25.0%	21.6%	20.8%	20.4%	20.1%
Staff Engagement	w		Sickness	5.0%	7.4%	6.3%	4.2%	
	w		Safeguarding Children Training	85.0%	85.7%	85.5%	86.8%	86.0%
Financial Position	w		Total Pay	0.0%	0.3%	0.5%	1.7%	0.2%
Carbon Footprint	w		CO2e Waste (tonnes/day)	0.28	0.23	0.21	0.21	
	w		CO2e Electricity (tonnes/day)	18.00	17.32	17.44	17.31	
	w		CO2e Water (tonnes/day)	0.55	0.42	0.56	0.52	
Med. Fit for Disch.	w		MFFD: Assessment	5.0	2.4	3.7	1.3	0.7
Innovation	w		Virtual OP Appts - First	25.0%	43.0%	53.1%	54.5%	49.0%
	w		Virtual OP Appts - Follow Up	60.0%	60.5%	69.0%	67.8%	62.1%

Appendix 2: Glossary of Terms

Term	Description
A3 Thinking Tool	Is an approach to thinking through a problem to inform the development of a solution. A3 also refers to the paper size used to set out a full problem-solving cycle. The A3 is a visual and communication tool which consists of (8) steps, each having a list of guiding questions which the user(s) work through (not all questions may be relevant). Staff should feel sure each step is fully explored before moving on to the next. The A3 Thinking Tool tells a story so should be displayed where all staff can see it.
Breakthrough Objectives	3-5 specific goals identified from True North. Breakthrough Objectives are operational in nature and recognised as a clear business problem. Breakthrough Objectives are shared across the organisation. Significant improvement is expected over a 12 month period.
Business Rules	A set of rules used to determine how performance of metrics and projects on a scorecard are discussed in the Care Groups Monthly Performance Review Meetings.
Catchball	<p>A formal open conversation between two or more people (usually managers) held annually to agree the next financial year's objectives and targets. However, a 6 monthly informal conversation to ensure alignment of priorities is encouraged to take place. The aims of a Catchball conversation are to:</p> <ol style="list-style-type: none"> (1) reach agreement on each item on a Scorecard e.g. driver metrics, watch metrics tolerance levels, corporate/ improvement projects. (2) Agree which projects can be deselected. (3) Set out Business Rules which will govern the process moving forward.
Corporate Projects	Are specific to the organisation and identified by senior leaders as 'no choice priority projects'. They may require the involvement of more than one business unit, are complex and/or require significant capital investment. Corporate Projects are often too big for continuous daily improvement but some aspect(s) of them may be achieved through a local project workstream.
Countermeasure	An action taken to prevent a problem from continuing/occurring in a process.
Countermeasure Summary	A document that summarises an A3 Thinking Tool. It is presented at monthly Performance Review Meetings when the relevant business rules apply.

Appendix 2: Glossary of Terms

Term	Description
Driver Lane	A visual tool containing specific driver metric information taken from the A3 (e.g. problem statement, data, contributing factors, 3 C's or Action Plan). The driver lane information is discussed every day at the improvement huddle and in more detail at weekly Care Group driver meetings and Monthly Performance Review Meetings. The structure of a driver lane is the same as the structure of a countermeasure summary.
Driver Meetings	Driver Meetings are weekly meetings that inform the Care Group of progress against driver metrics on their scorecard. Having a strong awareness of how driver metrics are progressing is vital for continuous improvement. Driver meetings also enable efficient information flow. They are a way of checking progress to plan.
Driver Metrics	Driver Metrics are closely aligned with True North. They are specific metrics that Care Group's choose to actively work on to "drive" improvement in order to achieve a target (e.g. 'reduce 30 day readmissions by 50%' or 'eliminate all avoidable surgical site infections'). Each Care Group should aim to have no more than 5 Driver Metrics.
Gemba Walk	'Gemba' means 'the actual place'. The purpose of a Gemba Walk is to enable leaders and managers to observe the actual work process, engage with employees, gain knowledge about the work process and explore opportunities for continuous improvement. It is important those carrying out the Gemba Walk respect the workers by asking open ended questions and lead with curiosity.
Huddles (Improvement Huddle) Boards	<p>Huddle or Improvement Boards are a visual display and communication tool. Essentially they are a large white board which has 9 specific sections. The Huddle or Improvement Boards are the daily focal point for improvement meetings where staff have the opportunity to identify, prioritise and action daily improvement ideas linked to organisational priorities (True North). The Huddle or Improvement Board requires its own Standard Work document to ensure it is used effectively.</p> <p>The aims of the Huddle/Improvement board includes:</p> <ol style="list-style-type: none"> 1. help staff focus on small issues 2. prioritise the action(s) 3. gives staff ownership of the action (improvement)
PDSA Cycle (Plan Do Study Act)	PDSA Cycle is a scientific method of defining problems, developing theories, planning and trying them, observing the results and acting on what is learnt. It typically requires some investigation and can take a few weeks to implement the ongoing cycle of improvement.
Performance Board	<p>Performance boards are a form of visual management that provide focus on the process made. It makes it easy to compare 'expected versus actual performance'. Performance Boards focus on larger issues than a Huddle Board, e.g. patient discharges by 10:00am. They help drive improvement forward and generate conversation e.g.:</p> <ol style="list-style-type: none"> 1. when action is required because performance has dropped 2. what the top 3 contributing problems might be 3. what is being done to improve performance

Appendix 2: Glossary of Terms

Term	Description
Scorecard	<p>The Scorecard is a visual management tool that lists the measures and projects a ward or department is required to achieve. These measures/projects are aligned to True North. The purposes of a Scorecard include:</p> <ol style="list-style-type: none"> 1. Makes strategy a continual and viable process that everybody engages with 2. focuses on key measurements 3. reflect the organization's mission and strategies 4. provide a quick but comprehensive picture of the organization's health
Standard Work	<p>Standard work is a written document outlining step by step instructions for completing a task or meeting using 'best practice' methods. Standard Work should be shared to ensure staff are trained in performing the task/meeting. The document should also be regularly reviewed and updated.</p>
Strategy Deployment	<p>Strategy Deployment is a planning process which gives long term direction to a complex organisation. It identifies a small number of strategic priorities by using an inch wide mile deep mindset and cascades these priorities through the organisation.</p>
Strategy Deployment Matrix	<p>A resource planning tool. It allows you to see horizontal and vertical resource commitments of your teams which ensures no team is overloaded.</p>
Strategic Initiatives	<p>'Must Do' 'Can't Fail' initiatives for the organisation to drive forward and support delivery of True North. These programmes of work are normally over a 3-5 year delivery time frame. Ideally these should be limited to 2-3. Initiatives are necessary to implement strategy and the way leaders expect to improve True North metrics over time (3-5 years).</p>
Structured Verbal Update	<p>Verbal update that follows Standard Work. It is given at Performance Review Meetings when the relevant business rules apply.</p>
Tolerance Level	<p>These levels are used if a 'Watch Metric' is red against the target but the gap between current performance and the target is small or within the metrics process control limits (check SPC chart). A Tolerance Level can be applied against the metric meaning as long as the metrics' performance does not fall below the Tolerance Level the Care Group will continue watching the metric.</p>
True North	<p>True North captures the few selected organisation wide priorities and goals that guide all its improvement work. True North can be developed by the Trust's Executive team in consultation with many stakeholders. The performance of the True North metrics against targets is an indicator of the health of the organisation.</p>
Watch metrics	<p>Watch metrics are measures that are being watched or monitored for adverse trends. There are no specific improvement activities or A3s in progress to improve performance.</p>

REPORT TO:	COUNCIL OF GOVERNORS
DATE:	20 MAY 2021
REPORT TITLE:	CONSTITUTION AND POLICY REVIEW GROUP REPORT
SPONSOR:	
PAPER AUTHOR:	GOVERNOR AND MEMBERSHIP LEAD
PURPOSE:	TO AGREE
APPENDICES	Appendix 1: proposed constitutional changes Appendix 2: list of policies/guidance to be considered Appendix 3: guidance from NHS Providers

BACKGROUND AND EXECUTIVE SUMMARY

This report summarises the outcomes from the first meeting of the Constitution and Policy Review Group (C&PRG), which was held on 11 May 2021.

The C&PRG is a task and finish group convened to undertake a review of the Trust Constitution and the policies and guidance relating to the work of Council.

The group comprises:

- Governors Alex Lister (Chair), Carl Plummer, Bernie Mayall, Ross Britton and Ken Rogers
- Non-Executive Director Nigel Mansley
- Group Company Secretary Alison Fox

Carl was unfortunately unable to attend the first meeting and Ross kindly agreed to step in at short notice. Both governors will continue on the group moving forward.

Prior to the meeting the group was provided with a list of the issues already identified to be considered for change within the Constitution and had an opportunity to add further items. To help inform the meeting, the Trust had arranged for comments to be provided from NHS Providers in relation to proposed constitution changes. The current versions of the policies and guidance were also provided along with copies of the Constitution, the FT Model Constitution and the Monitor Code of Governance.

It should be noted that amendments must have the support of over half of both Council and Board. Any amendments to the Constitution must comply with schedule 7 of the 2006 National Health Services Act, otherwise they have no effect, and must then be taken to the next Annual Public Meeting of the trust. Any changes affecting the role of the Governor will need approval at that meeting.

The Group first considered the proposed Constitution issues and at Appendix 1 is a summary of the discussion and the recommendations that we are making for governors to discuss and decide if Council wishes to propose these formally by way of a paper to the Board of Directors meeting on 27 May 2021.

With respect to the policies and guidance work; the Group agreed that this work would require significantly more time to complete and that there was a greater priority to review some of the documents above others. The Group Company Secretary agreed to annotate the list of documents to indicate which are in the purview of: the Council; the Board; or both.

This list is presented at Appendix 2. Guidance issued by NHS Providers with respect to the length of governor service is provided at Appendix 3, for information.

The Group will meet again on 10 June to take this work forward, recognising that there is preparatory work which can be undertaken in the meantime to ensure the task is progressed without undue delay.

The revisions of the policies and guidance will be brought to the Council for discussion and agreement.

LINKS TO STRATEGIC OBJECTIVES:

We care about...

- **Our patients;**
- **Our people;**
- **Our future;**
- **Our sustainability;**
- **Our quality and safety.**

RECOMMENDATIONS AND ACTION REQUIRED:

The Council of Governors is asked to:

1. consider and respond to the recommendations made in Appendix 1; and
2. note the proposed workplan for the C&PRG.

11 Constitution and Policy review group – Appendix 1

Ref	Description	Constitution reference	Constitution and Policy Review Group discussion Recommendation to Council
1.	<p>Voting Should the need arise for a confidential vote which should not be very often then this needs to be carried under proper conditions and within an agreed timeslot</p>	<p>Annex 7 Section 3.12 Voting</p>	<p>Points noted:</p> <ul style="list-style-type: none"> • Confidential votes should be the exception, not the norm. • Confidential needs to be absolute – no one should know how individuals voted. • The term Confidential needed to be defined clearly in the constitution. • The Constitution already defined some votes which must be confidential – such as those involving disciplinary processes and these should be retained. • The Constitution definition of when a vote should be confidential should not be too proscriptive; there needed to be flexibility to adjust to circumstances while avoiding a cumbersome process that would require a vote on whether a vote was confidential before it could be taken. • There should be a clear time frame for the vote and it should not be counted until this expires. • AF advised that the pandemic had brought the issue of virtual voting to the fore and was being discussed nationally. The direction of travel was that software needed to be used for virtual voting and there may be changes to Company Law in the future to support proper process. • Admin control had a virtual voting feature which could be used. <p>Recommendation: Revise the Constitution to state that confidential votes are used in extremis by agreement in Council and in a way which ensures that the individual's votes remain private. The timeframe for confidential votes to be five days, but can be shorter if required, by agreement with Council.</p>
2.	<p>Virtual Voting Making voting in virtual votes mandatory</p>	<p>Annex 7 3.12 Virtual voting</p>	<p>Points noted:</p> <ul style="list-style-type: none"> • On a practical basis, voting cannot be made mandatory; there will be circumstances where a governor cannot vote, due to illness for example, and this cannot be allowed to invalidate a voting process. • The problem which has occurred with virtual voting recently was in reaching the required % of governors voting, especially as governor numbers reduced; currently 75%.

	<p>Practical issue: abstaining in a virtual vote has the same effect as a no vote when calculating the % agreement. Should this be addressed?</p>		<ul style="list-style-type: none"> • Voting in a face to face meeting is based on a simple majority of those present, as long as quoracy has been met. Virtual voting is currently based on a % of the number in Council with 65% of those being in agreement to pass the vote. • On the basis that a secure electronic system can be introduced for electronic voting, the vote should be based on the number of governors in Council and be passed by a simple majority, unless already stated otherwise in the Constitution. • Public governors must be the majority of those voting. • There should be options for Yes/No/Abstain. • Abstain is a neutral vote. <p>Recommendation Revise the Constitution so that virtual voting is undertaken via a secure electronic system and passed by a simple majority of the number of governors on Council, unless already stated otherwise in the Constitution. Public Governors must be the majority of those voting.</p>
<p>3.</p>	<p>Governor Term of Office The max term of Governors of nine years to be removed.</p>	<p>16.3 Governor Tenure</p>	<p>Points noted:</p> <ul style="list-style-type: none"> • Given the time taken for governors to learn the role, coupled with the low numbers stepping forward for election, it was not of benefit to the Trust to have a maximum term. • This had resulted in positions becoming vacant for a significant period of time when an incumbent was forced to leave because they had reached the maximum term. • There was difference between the role of the Non-Executive Director (NED) and the Governor which meant that the argument that there should be maximum terms to maintain independence and fresh view points was relevant for NEDs, not for governors. • Over time governors built up skills and knowledge to perform well in the role and this experience should not be lost to the whim of having a maximum term of office. • Governors were elected by their constituents; therefore their constituents should be responsible for deciding when they were no longer fit for the role. • This was a democratic process, and such restrictions on length of term did not apply to any other similar role, such as MPs, Councillors or School governors. It should not be applied to the Council of Governors. • The Constitution recognised that all governors were the same, so there should be no distinction between public, staff and partner governors.

			<ul style="list-style-type: none"> • Nigel Mansley noted that there was a 10 year restriction on taking public service roles. • AF noted that NHSEI had advised that they were not in favour of agreeing to removing the maximum term; in the current climate it is incumbent on the Board to consider such advice with care. • KR noted that there was no justification for the Board to be influenced by NHSEI. There did need to be clearly recorded reasons as to why the Board held a view and what that view is in detail. • A decision taken to remove the maximum term could be revisited when governor elections attracted higher numbers of candidates with good experience and skills to offer. At present having a maximum term was not constructive. • AL commented that other Trusts were removing the maximum term requirement. AF noted that one Trust had done so, it was now trying to reverse the decision. <p>Recommendation That the maximum term of office be removed from the Constitution.</p>
4.	Taking over a term of office from another governor. Confirm that this is for the remainder of the term only. How is this counted with respect to the maximum term.	14.4 Council composition	<p>In discussion it was clarified that the point was raised because of the link to item 3 above: when the first term for is shorter than the normal 3 years (because they have stepped into a vacated position mid term), if they serve for three terms the total years they will have served will be less than 9. Governors in this position wishing to stand again could only serve part of the term, or they would exceed the maximum of nine years.</p> <p>It was noted that the principle that governors stepping into a vacated position serve out the existing term of office for that post was designed to keep Governor elections in an annual cycle as far as possible as Governor end of terms of office would occur in the same month each year. This avoided the costs of repeated elections, both in monetary and staff resource terms.</p> <p>It was agreed that this point only became relevant if the recommendation made at reference 3 was not supported by the Board. If that happened, then the Board should suggest how this reference (4) should be taken forward. AF noted that the Trust’s approach was standard across the NHS.</p> <p>Recommendation</p>

			The Board to be asked to propose how to resolve this conundrum if they do not support the recommendation at reference 3.
5.	Composition of Council Council to consider how to manage the vacancies created by recent resignations.	N/A	It was confirmed that this item was no longer relevant as it related to the time when there were vacancies on the Council which did not attract any candidates when elections were run.
6.	Allowing partner governors to have deputies	Annex 4 Annex 7 Section 3.18 Quorum	<p>Points noted:</p> <ul style="list-style-type: none"> • Alternate would be a better description than deputy. • That said, it was difficult to see how the needs of the fit and proper persons test could be met if a partner governor could deputise. • Similarly, there were problems around understanding issues and continuity. • Deputising should only be undertaken by another governor, for example Ross standing in for Carl at this meeting. • The constitution should be checked to ensure the definition for partner governors is consistent and clear. <p>Recommendation This change should not be accepted. Check to ensure the definition for partner governors is consistent and clear.</p>
7.	Looking at Governors standing down when they move out of area mid term.	Section 16 16.2	<p>Points noted:</p> <ul style="list-style-type: none"> • Similar issues expressed as for reference 3 above in relation to losing experience and creating a vacancy which may be difficult to fill. • Councillors are not required to resign if they move out of area mid-term. • Governors moving slightly out of their constituency area may still be able to represent members in that area, it would be more difficult if the move was further away as the local issues would be different. <p>Recommendation No change proposed.</p>
8.	Involving younger members in Council meetings.	N/A	This is an issue for the MECC to take forward. Minimum age for members is 16 and they are eligible to stand for election.

9.	<p>NED Appointments The Council is responsible for voting on the need and help required when considering the engagement of NEDs</p>	Annex 7 Section 5.2 Nominations & Remuneration Committee	<p>Points noted: Fully accepted. Noted that support from external recruitment consultants was of value but should be for the Council to decide on the scope and manage the procurement.</p> <p>Recommendation That the policy for recruiting NEDs be explicit on this point.</p>
10.	<p>All of terms of NEDs will only be renewed after the position has been put out to competition. Make open recruitment a requirement when filling all NED vacancies – going to advert, not just considering the performance of the incumbent if they are open to a further term</p>	Annex 7 Sections 8 and 9 Process for the appointment of NEDs/Chair respectively	<p>As the discussion developed it was recognised that references 10 and 11 were closely linked and should therefore be taken together.</p> <p>Points noted:</p> <ul style="list-style-type: none"> • The principle should be that the default should be to go to open recruitment. If a NED is seeking or open to a second term, there must be clear evidence that their performance has been to a high standard, they deliver on objectives and that their skill set meets the requirements for a balance on the Board at that time. • Nigel Mansley was invited to comment. He noted that as a NED he could be seen to have a slight conflict on this issue, though he was now in his second term so had no personal conflict. He cautioned that requiring open competition for all vacancies risked losing a good NED; participating in an open recruitment process took up time and this may deter an incumbent NED from seeking a further term.
11.	<p>Governors will have an input to the annual review of NEDs and the objectives.</p>		<ul style="list-style-type: none"> • In his view NED positions should not be for those needing the salary, they needed to be independent. Without the monetary element in play, there was less incentive to voluntarily submit to a recruitment process you may not be successful in. • Council had responsibility for NED appraisal, working with the Chairman and the Senior Independent Director as appropriate. • AL noted that he could only recall one objective setting/appraisal process for NEDs since he became a governor. • AF acknowledged that the process had not been as regular as it should have been; some of that was due to the instruction from the centre that appraisal processed be suspended during the pandemic. • It was agreed that appraising performance in a robust and objective manner was essential if this was to be a key element in considering a second term of office for a NED.

			<p>Recommendation Take these points forward as part of the review of the NED Appraisal and Recruitment policies. Ensure that the documents make it clear how a judgement is to be made on whether a second term of office is offered to a NED or if the vacancy is to go to open recruitment. It was not agreed to make open recruitment mandatory.</p>
12.	<p>Composition of the Board</p> <p>That should the balance of Executive and Neds on the board not have a greater number of NEDs the Council can make a temporary appointment or arrangements.</p> <p>To increase the maximum number of NEDs on the Board from 7 to 8, excluding the Chair.</p> <p>Should the constitution cover appointment of Associate and/or Non-Voting NEDs.</p> <p>Should there be specific reference to representation on the Board or Council from the Medical School.</p> <p>Having representation on Board/Council from the Medical School</p> <p>Remove reference to SECamb as an Appointed Governor</p>	<p>Section 25</p> <p>Annex 4</p>	<p>Points noted:</p> <ul style="list-style-type: none"> • Constitutionally there must be at least one more NED on the Board than Executives. • The run of NED resignations at the end of last year presented a problem as it meant that the Executives out-numbered the NEDs. • This was managed via a number of temporary measures including making the Associate NED a voting member and making temporary appointments. This had been out-with the Constitution and required formal agreement from Council. • Non-voting NEDs and Executive Directors and Associate Directors need to be defined within the Constitution. • Increasing the number of NEDs on the Board to eight excluding the Chairman was agreed. • The current Associate NED position was specifically for a representative from the Medical School. The Universities Partner Governor role provides similar representation on the Council. <p>Recommendation Revise the Constitution to:</p> <ul style="list-style-type: none"> • Increase the maximum number of NEDs on the Board to eight excluding the Chairman. • Define Non-voting NEDs and Executive Directors. • Define Associate Directors • Remove the reference to SECamb.

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Appendix 2

Ref.	Policy	Documents	Purview
1.	Appraisal Chair and NEDS, guidance	<ul style="list-style-type: none"> • Chair and NED appraisal process • Annex A – toolkit • Annex B – form • Annex C – performance form 	Council
2.	Governor Code of Conduct (including the media policy)	<ul style="list-style-type: none"> • Code of Conduct • Appendix 1 – governor role • Appendix 2 – Media policy • Appendix 3 – Nolan principles 	Trust
3.	Recruitment guidance	Joint document for Chairman and NEDs	Council
4.	Dispute resolution	One document	Joint
5.	Travel and Expenses policy	One document	Trust
6.	Managing allegations of breach	<ul style="list-style-type: none"> • Process for managing allegations • Annex A – Flow chart • Annex B - Examples 	Joint
7.	Fit and Proper Persons Policy	One document	Trust

How many terms should foundation trust governors serve?

The question 'what is best practice?' with regard to the maximum number of terms governors should serve is one that we are asked quite frequently. There is nothing in statute that limits the number of consecutive terms a governor can remain on the council, but foundation trusts can amend their constitutions to limit the number of terms. Most important, as we explore below, best practice suggests a sensible limit to the time governors can serve, in line with the practice for non-executive directors (NEDs).

Typically foundation trusts have been guided by the foundation trust code of governance provisions in respect of NEDs, because, rather unhelpfully, the code does not address the number of governor terms. The relevant paragraph states:

'Any term beyond six years (eg, two three-year terms) for a non-executive director should be subject to particularly rigorous review and should take into account the need for progressive refreshing of the board. Non-executive directors may, in exceptional circumstances, serve longer than six years (e.g., two three-year terms following authorisation of the NHS foundation trust) but this should be subject to annual re-appointment. Serving more than six years could be relevant to the determination of a non-executive's independence.'

This makes absolute sense for NEDs because their independence is essential in ensuring good corporate governance. It is an accepted that NEDs tend to take a less independent perspective over time as they develop closer working relationships with executive directors. This in turn can make it more difficult for the board to challenge effectively and properly to oversee the work of the executive.

But is the same true of governors? To obtain a sense of direction we need to look at two of the council of governors key statutory duties: the duty to represent the interests of members and of the public and the duty to ensure that the board is answerable for its performance via the non-executive directors. Both of these duties require an outside perspective and a degree of independence. If governors are too distant from the public, they will find it hard to come together as a council to represent the public's interest to the board. We would argue that the ability to understand the public perspective diminishes over time as governors identify more closely with the board, and the trust and its staff, and less closely with the public. And if governors are too close to the board, they will find the process of holding to account very difficult, particularly if that involves some tough conversations about things that are not progressing well. A degree of distance and objectivity that is not influenced by relationships is important. So for governors like their NED colleagues, independence is vital and while there is nothing specific in the code of governance it is both good sense and good practice for trusts to seek to refresh their council membership from time to time by limiting the number of consecutive terms governors can serve.

For NEDs, the code specifies two three-year terms. This is a reduction from three terms in previous iterations of the code and is a reflection of the fact that NEDs have frequent contact with the trust and can, in some cases, lose independence relatively quickly. Governors have less contact time with the trust and are therefore likely to take longer before they become more of a friend than critical friend.

However, most NEDs come onto boards as people with experience of operating at a very senior level and even if they don't have non-executive experience, they very often have executive board level experience. If NEDs need induction and to go through an intense learning process on joining the board of an NHS foundation trust, governors are often starting from scratch and many governors report that it takes most of their first term just to learn the role. In the case of governors, we must accept the reality that the vast majority of people need to learn the governor role from scratch. So perhaps for governors two terms is not long enough.

However, if the same governors regularly remain for longer than three terms, it seems likely to invite potential difficulties in terms of their independence and objectivity. The governor role is not similar to the role of directors and is not one of leadership and direction, but rather of representativeness and holding to account. There are no commensurate benefits to governors having additional experience over and above that they acquire early in their tenure which outweighs the potential loss of objectivity and independence that time in the role is bound to bring with it. So, we would contend that limiting the number of consecutive terms governors can remain in place to three is reasonable and constitutes good governance practice. Trusts might wish to allow former governors to return after a period of time, but there should arguably be a gap of at least one 3-year term.

Foundation trusts are permitted to make adjustments to their constitutions to limit governor terms under Paragraph 8(2) of Schedule 7 of the National Health Service Act 2006 as amended by the Health and Social Care Act 2012. Such changes require the approval of both the board and the council of governors and take effect immediately on the approval but need to be ratified by the next annual member's meeting to continue to be in force. We recommend that foundation trusts consider such amendments.

REPORT TO:	COUNCIL OF GOVERNORS
DATE:	20 MAY 2021
REPORT TITLE:	LEAD GOVERNOR AND DEPUTY LEAD GOVERNOR ELECTIONS
SPONSOR:	
PAPER AUTHOR:	GOVERNOR AND MEMBERSHIP LEAD
PURPOSE:	TO AGREE
APPENDICES	Appendix 1: Lead Governor role description Appendix 2: Deputy Lead Governor role description

BACKGROUND AND EXECUTIVE SUMMARY

This report presents a proposed schedule and draft role descriptions for the annual elections for the Lead Governor and Deputy Lead Governor posts.

Draft role descriptions

The Lead Governor role description is at Appendix 1. The changes from the document used last year are highlighted in yellow.

The Deputy Lead Governor role description is at Appendix 2 and is a new document. The role was introduced last year and Council chose to recruit to this post against the Lead Governor role. Practical issues arose during the year which highlighted that it would be helpful to have a role description in its own right.

It is suggested that the Lead Governor election is run first with the following timetable:

- 21 May issue invitation to stand, with the role description as agreed the day before. Deadline for replies 4pm on 24 May.
- If an election is needed, candidates will be asked to complete a self-nomination form and return this by 10 am on 27 May.
- An email to Council for virtual vote will be sent on 27 May and close at 10 am on 1 June.
- The aim will be to carry out the virtual vote via Admin control so that it is confidential.

The Deputy Lead Governor election to start when the Lead Governor election closes on either 24 May, if uncontested, or 1 June if there is an election.

- Invitation to stand: 24 May or 1 June, closing 26 May or 3 June.
- Declared on 3 June if uncontested
- Self nomination forms completed 7 June if contested
- An email to Council for virtual vote sent on 7 June and close at 10 am on 10 June.

LINKS TO STRATEGIC OBJECTIVES:	We care about... <ul style="list-style-type: none"> • Our patients; • Our people; • Our future;
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	<ul style="list-style-type: none">• Our sustainability;• Our quality and safety.
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RECOMMENDATIONS AND ACTION REQUIRED:

The Council of Governors is asked to agree the:

1. role description for the Lead Governor;
2. role description for the Deputy Lead Governor; and
3. proposed timetables for the elections.

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Appendix 1

Lead Governor – role description

Roles and Responsibilities

A) To meet the duties laid out in legislation:

In keeping with NHS Improvement guidance the Lead Governor will:

- liaise between NHSI and the CoG where NHSI has raised concerns about the leadership of the Trust or where the lead governor or the council of governors by majority vote have decided that such liaison is necessary, particularly where the circumstances are such that it would be inappropriate for the Trust Chair to contact the NHSI.

In keeping with the Trust's Constitution the Lead Governor will:

- preside at meetings of the Council of Governors where:
 - matters relating to the Non-Executive Directors are being considered and, as a result, a conflict of interest exists relating to the Chairman and the Deputy Chairman – Section 2.1.3;
 - where the Chairman, Deputy Chairman, and other Non-Executive Directors are all absent or have a conflict of interest and the Lead Governor shall have a casting vote – section 3.6; and
- together with the Senior Independent Director (SID) and Director of HR, receive the Resolution of Disputes, Level 2 investigation report, discuss the recommendations and agree an action plan for implementation – section 6.6.

B) To be a conduit for sharing information and views between the Trust and Council, including meeting with the Trust Chair and canvassing Governors on items for Governor formal meeting agendas. The Lead Governor will keep the Council updated on the conversations.

C) To be a member of the Council of Governors Nominations and Remuneration Committee.

D) To attend all public Board meetings or arrange for the Deputy Lead Governor to deputise when needed and if possible.

The Lead Governor can ask the deputy to deputise for him for any part of his role at any time.

Term of Office:

The period of office will run from 1 June to 31 May each year.

If the Lead Governor has to step down during the term of office the role will be offered to the Deputy Lead Governor who will serve the remainder of the term. If the

Document ratified:



Deputy Lead Governor does not wish to take the role, an election will be run as quickly as possible and the successful candidate will serve the remainder of the term.

Person Specification:

The Lead Governor must be an elected Governor.

The following attributes are considered desirable for Governors standing for election to the Lead Governor role.

- a. To have the confidence of Governor colleagues and of members of the Board of Directors.
- b. To show adherence to the Nolan Principles.
- c. To have an understanding of the Trust's Constitution.
- d. To be able to commit the time necessary.
- e. To be IT literate.
- f. To have the ability to influence, negotiate and present a well-reasoned argument.

Holding the post of Lead Governor does not preclude the incumbent taking on the role of Chair for one of the Council's Committees.

Appendix 2

Deputy Lead Governor – role description

Roles and Responsibilities

To deputise for the Lead Governor with respect to the following elements of that role description:

A) To meet the duties laid out in legislation:

In keeping with NHS Improvement guidance the Lead Governor will:

- liaise between NHSI and the CoG where NHSI has raised concerns about the leadership of the Trust or where the lead governor or the council of governors by majority vote have decided that such liaison is necessary, particularly where the circumstances are such that it would be inappropriate for the Trust Chair to contact the NHSI.

In keeping with the Trust's Constitution the Lead Governor will:

- preside at meetings of the Council of Governors where:
 - matters relating to the Non-Executive Directors are being considered and, as a result, a conflict of interest exists relating to the Chairman and the Deputy Chairman – Section 2.1.3;
 - where the Chairman, Deputy Chairman, and other Non-Executive Directors are all absent or have a conflict of interest and the Lead Governor shall have a casting vote – section 3.6; and
- together with the Senior Independent Director (SID) and Director of HR, receive the Resolution of Disputes, Level 2 investigation report, discuss the recommendations and agree an action plan for implementation – section 6.6.

B) To be a conduit for sharing information and views between the Trust and Council, including meeting with the Trust Chair and canvassing Governors on items for Governor formal meeting agendas. The Lead Governor will keep the Council updated on the conversations.

...

D) To attend all public Board meetings ...

Term of Office:

The period of office will run from the election conclusion in June to 31 May each year.

If the Lead Governor has to step down during the term of office, the Deputy Lead Governor will be invited to serve the remainder of the term. If the invitation is accepted, a new election will be run for the Deputy Lead Governor post and the successful candidate will serve the remainder of the term of office.

Document ratified:



Person Specification:

The Deputy Lead Governor must be an elected Governor.

The following attributes are considered desirable for Governors standing for election to the Deputy Lead Governor role.

- a. To have the confidence of Governor colleagues and of members of the Board of Directors.
- b. To show adherence to the Nolan Principles.
- c. To have an understanding of the Trust's Constitution.
- d. To be able to commit the time necessary.
- e. To be IT literate.
- f. To have the ability to influence, negotiate and present a well-reasoned argument.

Holding the post of Deputy Lead Governor does not preclude the incumbent taking on the role of Chair for one of the Council's Committees.

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REPORT TO:	COUNCIL OF GOVERNORS
DATE:	20 MAY 2021
REPORT TITLE:	COMMITTEE MEMBERSHIP
SPONSOR:	
PAPER AUTHOR:	GOVERNOR AND MEMBERSHIP LEAD
PURPOSE:	TO AGREE
APPENDICES	Appendix 1: proposal for committee membership

BACKGROUND AND EXECUTIVE SUMMARY

This report provides a first cut proposal for membership of the Council of Governor Committees, Appendix 1 below..

This has been based on the preferences expressed by those governors who returned the Skills and Training Audit proforma and taking into account the criteria previously set by Council:

- each Committee to have eight member, including one staff governor and one partner governor;
- the membership to include governors who can demonstrate the skills needed for that committee as well as governors who have a strong interest in the work of the committee; and
- for the purposes of continuity, there should be at least one Governor on the Committee who was a member the previous year.

The work has assumed that the proposals within the Chairman's report on the Council Framework moving forward have been accepted. Membership is therefore proposed for a:

- Membership Engagement and Communication Committee (MECC)
- Audit and Governance Committee (AGC)
- Staff and Patient Experience Committee (SPEC)

Membership of the Nominations and Remuneration Committee (NRC) will be via volunteers as the need arises; minimum of one meeting per year.

Only seven members have been listed for each group. To have eight per Committee requires five governors to sit on two committees and only two governors have specifically confirmed that they are able to do so. Council may wish to consider whether:

1. Three volunteers are sought to sit on one more Committee each; or
2. Reduce the committee size to 7 given that there is also the NRC to form. Quoracy will have to remain at 4 to meet the Constitution.

LINKS TO STRATEGIC OBJECTIVES:

We care about...

- **Our patients;**
- **Our people;**
- **Our future;**
- **Our sustainability;**
- **Our quality and safety.**

RECOMMENDATIONS AND ACTION REQUIRED:

The Council of Governors is asked to discuss agree the proposed membership for Council committees.

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Appendix 1

	Audit & Governance	Staff & Patient Experience	Membership Engagement & Communication
Ashford			
John Fletcher			x
Nick Hulme	x		
Canterbury			
Alex Ricketts	x		
Alex Lister			x
Dover			
Bernie Mayall		x	
Paul Verrill			x
Folkestone & Hythe			
Carl Plummer			x
Liz Baxter		x	
Swale			
Ken Rogers	x		
Ross Britton	x	x	
Thanet			
Paul Schofield			x
Marcella Warburton	x	x	
Rest of England/Wales			
Chris Pink		x	
Staff			
James Casha	x		
Sally Wilson		x	
Sophie Pettifer			x
Partnership			
Bob Bayford	x		
Linda Judd			x
Debra Towse		x	