Queen Victoria Hospital
NHS Foundation Trust

Council of Governors
Meeting in public

Monday 17 April 2023

16.00-18.00
Education Centre, QVH

Queen Victoria Hospital NHS Foundation Trust
Council of Governors

Membership April 2023

Members	
Jackie Smith	Trust Chair
Chris Barham	Public governor
Elizabeth Bowden	Public governor
Andrew Brown	Public governor
Tim Butler	Public governor
Baljit Dheansa	Staff governor
Miriam Farley	Public governor
Anthony Fulford-Smith	Public governor
Janet Haite	Public governor
Oliver Harley	Public governor
Anita Hazari	Staff governor
Julie Holden	Stakeholder governor for EG Town Council
Bob Lanzer	Stakeholder governor for WS County Council
Raman Malhotra	Staff governor
Caroline Migo	Public governor
Linda Skinner	Stakeholder governor for League of Friends
Roger Smith	Public governor
Ken Sim	Public governor
Alison Stewart	Public governor
Peter Ward Booth	Public governor
Thavamalar Yoganathan	Public governor
Invited attendees	
Gary Needle	Senior independent director
Kevin Gould	Non-executive director
Paul Dillon-Robinson	Non-executive director
Karen Norman	Non-executive director
Tony Chambers	Interim Chief executive
Stuart Rees	Interim chief finance officer
Nicky Reeves	Chief nurse
Tania Cubison	Medical director
Lawrence Anderson	Interim director of workforce and OD
Shane Morrison-McCabe	Director of operations
Abigail Jago	Director of strategy and partnerships
Clare Pirie	Director of communications and corporate affairs
Leonora May	Deputy company secretary (minutes)

Annual declarations by governors 2023/24

As established by section 22 of the Trust's Constitution, if a governor of the Trust has a relevant and material interest, or a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose the nature and extent of that interest to the members of the Council of Governors as soon as he/she becomes aware of it.

To facilitate this duty, governors are asked on appointment to the Trust and thereafter at the beginning of each financial year, to complete a form to declare any interests or to confirm that the governor has no interests to declare (a 'nil return'). Governors must request to update any declaration if circumstances change materially. By completing and signing the declaration form governors confirm their awareness of any facts or circumstances which conflict or may conflict with the interests of QVH NHS Foundation Trust. All declarations of interest and nil returns are kept on file by the Trust and recorded in the following register of interests which is maintained by the Company Secretary.

	Directorships, including non-executive directorships, held in private companies or public limited companies (with the exception of dormant companies).	Ownership, part ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS or QVH.	Significant or controlling share in organisations likely or possibly seeking to do business with the NHS or QVH.	A position of authority in a charity or voluntary organisation in the field of health or social care.	Any connection with a voluntary or other organisation contracting for NHS or QVH services or commissioning NHS or QVH services.	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with QVH, including but not limited to lenders of banks.	Any "family interest": an interest of a close family member which, if it were the interest of that director, would be a personal or pecuniary interest.
Public governors							
Barham, Chris	Transcend Talent consultancy Limited- Non Executive Director	NIL	NIL	NIL	NIL	NIL	NIL
Bowden, Elizabeth							
Brown, Andrew	NIL	NIL	NIL	NIL	NIL	NIL	NIL
Butler, Tim	Innovation Visual Limited – Director Medical Stock Images Company Limited – Director Medical Artist Limited – Director 23 Clarence Square (Cheltenham) Management Limited - Director	Medical Stock Images Company Limited – Director, 50% ownership. Previously used by the NHS, not seeking to do business with QVH. Medical Artist Limited – Director, 50% ownership. Previously used by the NHS, not seeking to do business with QVH.	Medical Stock Images Company Limited – Director, 50% ownership. Previously used by the NHS, not seeking to do business with QVH. Medical Artist Limited – Director, 50% ownership. Previously used by the NHS, not seeking to do business with QVH.	NIL	NIL	NIL	NIL
Farley, Miriam							
Fulford-Smith, Antony	Director property management company with single asset – woodland in Devon	I have a consulting contract with a pharmaceutical company to advise on their organisational development (Ferring)	NIL	NIL	NIL	I hold share options in companies with whom previously employed that supply medicines to the NHS (Abbvie and Ipsen)	Spouse is matron of Maxillofacial and Orthodontic outpatients department at QVH
Haite, Janet	NIL	NIL	NIL	NIL	NIL	NIL	NIL
Harley, Oliver							
Migo, Caroline	NIL	NIL	Chair and Trustee of Restore Breast Cancer Reconstruction Charity	NIL	NIL	NIL	NIL
Sim, Ken	NIL	NIL	NIL	NIL	NIL	NIL	NIL
Smith, Roger	NIL	NIL	NIL	NIL	NIL	NIL	NIL
Stewart, Alison	NIL	NIL	NIL	NIL	Following my retirement, I retain a small partnership share, with a non-clinical role in an NHS general practice partnership in Tunbridge Wells, Kent.	NIL	My step daughter is an extended scope practitioner physiotherapist at QVH.
Ward Booth, Richard Peter	NIL	NIL	NIL	Vice Chair Uckfield League of Friends	NIL	NIL	NIL

Yoganathan, Thavamalar	Director at Tesaanth Healthcare Services limited. The focus of this company is the provision of healthcare in the private sector. We do not directly receive NHS referrals but do some contract work for Kent integrated dermatology services, who is an NHS provider.	NIL	NIL	NIL	NIL	NIL	Spouse is a consultant plastic surgeon at QVH.

	Directorships, including non-executive directorships, held in private companies or public limited companies (with the exception of dormant companies).	Ownership, part ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS or QVH.	Significant or controlling share in organisations likely or possibly seeking to do business with the NHS or QVH.	A position of authority in a charity or voluntary organisation in the field of health or social care.	Any connection with a voluntary or other organisation contracting for NHS or QVH services or commissioning NHS or QVH services.	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with QVH, including but not limited to lenders of banks.	Any "family interest": an interest of a close family member which, if it were the interest of that director, would be a personal or pecuniary interest.
Staff governors							
Dheansa, Baljit	Director of My Plastic Surgeon Ltd. This company manages my private practice in plastic and reconstructive surgery.	Director of My Plastic Surgeon Ltd. This company manages my private practice in plastic and reconstructive surgery. Although I do not intend to seek NHS work through my company it is possible that such work may be offered to me.	NIL	I am patron of Dan's Fund for Burns. The position is not one of authority as I have no voting powers.	NIL	NIL	My wife works in the NHS at a London Hospital in the field of neurosurgery
Hazari, Anita	Director of own private practice partnership (LLP)	NIL	NIL	Chair plastic surgery exams JCIE Specialist advisor breast surgery CQC	NIL	NIL	NIL
Malhotra, Raman	NIL	Owner and Director of Orbitofacial Clinic Limited. This is my private practice related to healthcare of patients with ophthalmic and oculoplastic disorders. Outpatient clinics are carried out at the McIndoe Centre, Spire Gatwick Park Hospital and Harley Street Specialist Hospital, London. Surgery is carried out at these sites and also at Centre For Sight, East Grinstead. I do not receive NHS referrals. Co-director of Palm Vision LLP, a company set up to grow palm trees.	NIL	NIL	NIL	NIL	NIL
Appointed governors							
Holden, Julie	NIL	NIL	NIL	NIL	NIL	NIL	NIL
Lanzer, Bob	Director of Southeast Communities Rail Partnership CIC (Communities Interest Company)	NIL	NIL	NIL	Member of West Sussex County Council and Cabinet Member for Public Health and Wellbeing Member of the Sussex Health and Care Assembly	NIL	NIL
Skinner, Linda	NIL	NIL	NIL	NIL	NIL	NIL	NIL

Fit and proper persons declaration

As established by regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the regulations"), QVH has a duty not to appoint a person or allow a person to continue to be a governor of the trust under given circumstances known as the "fit and proper person test". By completing and signing an annual declaration form, QVH governors confirm their awareness of any facts or circumstances which prevent them from holding office as a governors of QVH NHS Foundation Trust.

	Categories of person prevented from holding office						
	The person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged.	The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.	The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40).	The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.	The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.	The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.	The person has been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.
Public governors							
Barham, Chris	NA	NA	NA	NA	NA	NA	NA
Bowden, Elizabeth							
Brown, Andrew	NA	NA	NA	NA	NA	NA	NA
Butler, Tim	NA	NA	NA	NA	NA	NA	NA
Farley, Miriam							
Fulford-Smith, Antony	NA	NA	NA	NA	NA	NA	NA
Haite, Janet	NA	NA	NA	NA	NA	NA	NA
Harley, Oliver							
Migo, Caroline	NA	NA	NA	NA	NA	NA	NA
Sim, Ken	NA	NA	NA	NA	NA	NA	NA
Smith, Roger	NA	NA	NA	NA	NA	NA	NA
Stewart, Alison	NA	NA	NA	NA	NA	NA	NA
Ward Booth, Richard Peter	NA	NA	NA	NA	NA	NA	NA
Yoganathan, Thavamalar	NA	NA	NA	NA	NA	NA	NA
Staff governors							
Dheansa, Balj	NA	NA	NA	NA	NA	NA	NA
Hazari, Anita	NA	NA	NA	NA	NA	NA	NA
Malhotra, Raman	NA	NA	NA	NA	NA	NA	NA
Appointed governors							
Holden, Julie	NA	NA	NA	NA	NA	NA	NA
Lanzer, Bob	NA	NA	NA	NA	NA	NA	NA
Skinner, Linda	NA	NA	NA	NA	NA	NA	NA

Meeting of the QVH Council of Governors
Monday 17 April 2023
16.00-18.00

	Agenda: meeting session held in public			
Standing items				
Ref	**Item**	**purpose**	**papers**	**Indicative time**
1-23	**Welcome, apologies, declarations of interest and eligibility, confirmation of quoracy** *Jackie Smith, Trust Chair*	-	*Verbal*	*16.00*
2-23	**Draft minutes of the public meeting held on 9 January 2023** *Jackie Smith, Trust Chair*	*Approval*	*Paper*	*16.02*
3-23	**Matters arising and actions pending from previous meetings** *Jackie Smith, Trust Chair*	*Review*	*Paper*	*16.05*
Council business				
Ref	**Item**	**purpose**	**papers**	**indicative time**
4-23	**Securing the long term future of QVH** *Jackie Smith, Trust Chair*	*Information*	*Verbal*	*16.10*
5-23	**Update from interim chief executive** *Tony Chambers, interim chief executive officer*	*Information*	*Verbal*	*16.25*
6-23	**Code of Governance for NHS provider trusts and addendum to Your Statutory Duties: a reference guide for NHS foundation trust governors** *Clare Pirie, director of communication and corporate affairs*	*Information / discussion*	*Paper*	*16.40*
7-23	**Update from Governor working group on public engagement** *Antony Fulford-Smith, committee Chair*	*Information*	*Verbal*	*16.50*
Holding non-executive directors to account for the performance of the board of directors				
Ref	**Item**	**purpose**	**papers**	**indicative time**
8-23	**Finance and performance committee** *Paul Dillon- Robinson, Committee Chair*	*Information*	*Paper*	*16.55*
9-23	**Digital committee** *Kevin Gould, Committee Chair*	*Information*		
10-23	**Quality and governance committee** *Karen Norman, Committee Chair*	*Information*		

11-23	**Audit committee** *Kevin Gould, Committee Chair*	*Information*		
12-23	**Any other questions for non-executive directors** *All members of Council of Governors*	*Discussion*		*17.25*
Meeting closure				
Ref	**Item**	**purpose**	**papers**	**indicative time**
13-23	**Any other business** *By application to the Chair*	*Discussion*	*Verbal*	*17.40*
Questions				
Ref	**Item**	**purpose**	**papers**	**indicative time**
14-23	**To receive any questions or comments from members of the foundation trust or members of the public** *We welcome relevant, written questions on any agenda item from our staff, our members or the public. To ensure that we can give a considered and comprehensive response, written questions must be submitted in advance of the meeting (at least three clear working days). Please forward questions to Leonora.may1@nhs.net clearly marked "Questions for the Council of Governors". Members of the public may not take part in the Council of Governors discussion. Where appropriate, the response to written questions will be published with the minutes of the meeting.*	*Discussion*	Verbal	*17.45*
Date of next meeting				
Next meeting of the council of governors to be held in public				
17 July 2023				

Quoracy

Any meeting of the Council of Governors requires a quorum of at least half of the total number of Governors to be present, with a majority of those present being Public Governors. No business shall be carried out at a meeting which is not quorate.

Document:	Minutes DRAFT & UNCONFIRMED	
Meeting:	**Council of Governors session in public** **15.00-17.00 Monday 9 January 2023** **Via Microsoft Teams**	
Present:	Jackie Smith (JS)	Trust Chair
	Chris Barham (CB)	Public governor (lead governor)
	Andrew Brown (AB)	Public governor
	St John Brown (StJB)	Stakeholder governor LoF
	Tim Butler (TB)	Public governor
	Janet Haite (JDH)	Public governor
	Julie Holden (JWH)	Stakeholder governor, EGTC
	Bob Lanzer (BL)	Stakeholder governor WSCC
	Caroline Migo (CM)	Public governor
	Ken Sim (KS)	Public governor
	Roger Smith (RS)	Public governor
	Alison Stewart (AS)	Public governor
	Peter Ward Booth (PWB)	Public governor
	Antony Fulford-Smith (AFS)	Public governor
	Thavamalar Yoganathan (TY)	Public governor
	Anita Hazari (AH)	Staff governor
	Elizabeth Bowden (EB)	Public governor
In attendance:	Leonora May (LM)	Deputy company secretary (minutes)
	Clare Pirie (CP)	Director of communication and corporate affairs
	Gary Needle (GN)	Senior independent director
	Karen Norman (KN)	Non-executive director
	Paul Dillon- Robinson (PDR)	Non-executive director
	Steve Jenkin (SJ)	Chief executive officer
	James Drury (JD)	Interim chief finance officer
	Nicky Reeves (NR)	Chief nurse
	Tania Cubison (TC)	Medical director
	Shane Morrison-McCabe (SMM)	Director of operations
	Lawrence Anderson (LA)	Interim director of workforce and OD
Apologies:	Miriam Farley (MF)	Public governor
	Baljit Dheansa (BD)	Staff governor
Did not attend:	Raman Malhotra (RM)	Staff governor
	Oliver Harley (OH)	Public governor (excluded)
Members of the public:	One member of public	
Ref.	Item	
Standing items		
78-23	**Welcome, apologies and declarations of interest and eligibility** The Chair opened the meeting and welcomed Council, attendees and one member of public. The Chair reminded all present that the meeting was being recorded and that the meeting was a meeting in public and not a public meeting, therefore members of public were invited to observe the meeting but not participate in discussions. Apologies were received from MF and BD, and the meeting was quorate. There were no declarations of interest other than those already recorded on the register of interests.	
79-23	**Draft minutes of the Part A and Part B public meeting held on 28 November 2022** Governors raised that OH had been noted as having sent apologies to the meeting, and requested that the minutes be amended to make clear that he had been excluded from attending the meeting.	

	Subject to the above amendment being made, Council **agreed** that the minutes of the part A and part B public meeting held on 28 November 2022 were a true and accurate record of that two part meeting and **approved** them on that basis.
80-23	**Matters arising and actions pending from previous meetings** Minute ref 54-2 (minutes) TB confirmed that he would identify the conflicting opinion in the 18 July public CoG minutes so that the matter could be closed and final minutes published on the Trust's website. This action will remain as pending. Minute ref 70-22 (Federation of Specialist Hospitals) JS confirmed that she will meet with the Federation at the beginning of February hear more about what benefits they could deliver for QVH in order that costs of membership can be considered. A further update will be provided to Council at its next meeting and this action will remain as pending.
Holding non-executive directors to account for the performance of the Board of Directors	
81-23	**Finance and performance committee** PDR provided a verbal update on finance and performance committee meetings held since the last Board meeting. The committee had met on 28 November 2022 and its next meeting was scheduled for 11 January 2023. The highlights of the meeting held on 28 November were reported as follows: - Workforce- vacancy levels for the Trust are below 8%. The committee have had close oversight of sickness absence and continue to seek assurance that appraisals are being completed on time, and that they are effective - Operations- the Trust continues to report increased referrals in areas since the start of the pandemic. The committee remain focussed on seeking assurance that the Trust will have no 78 week waits by the end of March 2023 and concern was raised regarding the Trust meeting its 52 week wait target due to increased referrals and ongoing operational pressures - Finance- this year the Trust is predicting a break even position at year end, although there is ongoing concern regarding the Trust's financial position in the next financial year with movement towards aligned payment and incentive contracts Council considered and discussed the finance and performance committee update as follows: - JD confirmed that the aligned payment and incentive contracts will relate to elective activity only. NHS Sussex will have an elective target that will be broken down into trust activity targets. If the Trust does not hit its target, it may be subject to income claw back - Discussion was had regarding clinical coding, and PDR confirmed that the finance and performance committee had received assurance at its October meeting that all actions to improve the position had been completed and that the Trust's clinical coding function is working well and the Trust is now able to deliver robust data to NHS England - PDR confirmed that increased referrals post pandemic were thought to be due to patients' treatment being delayed during the pandemic, increased activity in the minor injuries unit and another sleep service closing down. Council noted that QVH is supporting the system with elective activity where other providers are significantly challenged - Discussion was had regarding the 130% elective activity target versus 2019/20 and JD confirmed that there is additional funding through the elective recovery programme, although there is a significant increase to make in order for QVH to meet the target - Council noted that QVH benchmarks lower than the national and regional average for staff sickness, although staff sickness levels have increased Council **noted** the finance and performance committee update.
82-23	**Quality and governance committee** KN provided a verbal update on the quality and governance committee meeting held on 20 December 2022, reporting that: - Clinical quality- one serious incident had been reported and this related to an incident in June 2021. The committee supported a recommendation that a quality improvement project on medical errors will be completed

	- Clinical harm- the committee remain focussed on seeking assurance related to clinical harm. There have been no patients identified with severe or moderate harm due to waiting during the period, although the committee remain concerned about the length of waiting lists - National reports- the committee received three national investigation reports and will continue to support the implementation of learning for the Trust In response to a request from a governor the non-executive directors agreed to seek assurance related to productivity at QVH and the programmes in place to make improvements. Council **noted** the quality and governance committee update.
83-23	**Audit committee** PDR introduced the item and reported that the audit committee had met on 7 December 2022. He reported that the procurement team had undertaken a soft market testing exercise to understand if there is any interest in providing QVH's external audit services, and that the market remains challenging. Council **noted** the audit committee update.
84-23	**Any other questions for non-executive directors** There were no further questions for the non-executive directors. The Chair reminded governors that the next public Board meeting is being held on 12 January 2023 and that they are invited to observe the meeting.
Council business	
85-23	**Securing the long term future of QVH** The Chair provided a verbal update on work to secure the long term future of QVH, reporting that the Board had received an update on the clinical stock take work completed to date at its seminar on 1 December 2022, and that there remains a lot of work to be done in developing a strategy and vision for QVH. Governors requested a date for completion of ongoing work streams and the Chair shared an indicative timeline, stating that she thought the clinical stock take work would be completed within the next three months, and the strategy and vision could be developed within the next six to nine months. She emphasised that these timelines are indicative and subject to change, and that engagement alongside work streams will be paramount. Council **noted** the update.
86-23	**Annual planning for 2023/24** JD presented an update on business planning for 2023/24, the highlights of which were as follows: - Efficiencies- expectation of 3% which includes tariff efficiency (1.1%), convergence (0.6%) and Covid funding reduction (c. 80% reduction of 2022/23 funding). The efficiency ask excludes the impact of recovering any 2022/23 system deficits. An efficiency plan is being developed - Elective activity- targets will be an additional 10% on national performance year to date. There is a significant risk to the Trust through potential lower level of income crystallising underlying deficit - Inflation- there is a risk of inflation impact on the cost base above funded levels driving worsening of the financial position - Budget- the 2023/24 budget is being reviewed and restated based on current expenditure - NHS pay rise- there is an assumption that NHS staff will receive a 2% pay rise next year, and anything above 2% will likely be covered by NHS England Council discussed the contents of the presentation as follows: - In response to a question from a governor, JD outlined the Trust's top costs outside of wages, being utilities, clinical negligence claims and liabilities, medical equipment and maintenance contracts. He confirmed that the Trust is seeking to go out to tender for its utilities contract - JD confirmed that other systems within the region were also over their allocation for the current year and that this year, NHS England have capped 0.71% for 39 out of 42 systems. The systems that have not been capped are ones which have been under funded

	Council **noted** the contents of the presentation.
87-23	**Non-executive director (NED) appointments** [This item was taken after item 90-23, and GN had left the meeting] KS presented the report to Council, reporting that the appointments committee had considered the recommendations set out within the report at its meeting on 7 December 2022, and had agreed to recommend them to Council for approval, with the length of Gary Needle's extension to be determined. Discussion was had regarding the extension of Gary Needle's appointment as a NED and the Trust Chair emphasised that: - QVH has a small number of NEDs in comparison to other trusts - that there are significant demands on QVH NEDs - that Gary Needle has invaluable experience in strategic change - that the current market for recruitment of NHS NEDs is challenging A number of governors did not support the extension of Gary Needle's appointment. AFS stated that he was in favour of the extension, recognising the requirement for continuity. In response to questions from governors, the Trust Chair confirmed that the recruitment process for the two NEDs will be an open recruitment process, and not limited to NEDs with previous NHS experience. The recommendation that GN's appointment as a NED be extended to support continuity in the context of executive and NED Board changes was **not approved** and it was agreed that this proposal would be revisited once preferred candidates for the two NED roles have been identified. Council **approved** the recommendation that the Trust will seek to recruit two NEDs, in succession of GN whose six year term ends on 30 June 2023, and Kevin Gould whose six year term ends on 31 August 2023.
88-23	**Appointments committee terms of reference** KS presented the appointments committee terms of reference, which were **approved** by Council.
89-23	**Governor steering committee terms of reference** CB presented the governor steering committee terms of reference, which were **approved** by Council.
90-23	**Update from governor working group on public engagement** AFS provided a verbal update on the governor working group on public engagement, reporting that he and another governor had attended an NHS Sussex engagement event at Age Concern, and that the members of public they had spoken to held QVH in high regard and had a good knowledge of the specialist services provided by QVH. Discussion was had regarding the newsletter which the governors working group had drafted for the Trust's membership, and in response to questions received from governors, CP confirmed that: - the Trust has circa 7,500 public members, and - approximately half of these members have provided QVH with their email address and confirmed that they are happy for the Trust to communicate with them via email - QVH News was sent to all members during December 2022. All members who had not provided an email address would have received the mailing via post, provided that their details were correct and up to date on the Trust's membership database Council **noted** the update. [item 87-23 was taken after this item, and GN left the meeting]
Meeting closure	
91-23	**Any other business** The Trust Chair highlighted that it was SJ's last Council meeting before leaving QVH on 13 January 2023. She extended thanks to SJ on behalf of the Board for his enormous contribution to QVH, its patients and staff during his six years as chief executive officer for the Trust. She commended him for for his work in leading QVH through the Covid-19 pandemic and standing up the cancer hub.

	The lead governor extended thanks to SJ on behalf of all governors, and SJ wished all well for the future, and thanked the governors, the League of Friends and East Grinstead Town Council for their support during his tenure.
Questions	
92-23	**Questions or comments from members of the foundation trust of members of the public** There were none. The Chair closed the meeting.

Matters arising and actions pending from previous meetings of the Council of Governors - PUBLIC								
ITEM	**MEETING Month**	**REF.**	**TOPIC**	**AGREED ACTION**	**OWNER**	**DUE**	**UPDATE**	**STATUS**
1	November	54-22	Minutes	TB to highlight conflicting opinion in 18 July public CoG minutes for amendment.	**TB**	**31 December 2022**	Suggested amendments received and minutes amended and published to website.	**Complete**
2	November	70-22	Federation of specialist hospitals	Consider benefits versus cost and value for money of reinstating membership with Federation of specialist hospitals	**JS**	**9 January 2023**	Council received a verbal update from the Trust Chair at its meeting on 9 January 2023. Further verbal update to be provided at the meeting on 17 April 2023.	**Pending**

Report to:	Council of governors
Agenda item:	6-23
Date of meeting:	17 April 2023
Report from:	Clare Pirie, director of communications and corporate affairs
Report author:	Leonora May, deputy company secretary
Date of report:	11 April 2023
Appendices:	Appendix one: Code of governance for NHS provider trusts Appendix two: Addendum to Your statutory duties: reference guide for NHS foundation trust governors

Code of governance for NHS provider trusts and addendum to statutory duties

Introduction and background

NHS England have published a new code of governance for NHS provider trusts and an addendum to Your statutory duties: reference guide for NHS foundation trust governors, both of which sit under the new NHS provider licence published on 27 March 2023. These documents have been updated following the passing of the Health and Care Act 2022, updating governance arrangements where appropriate.

The new provider licence aims to support effective system working, enhance the oversight of key services provided by the independent sector, address climate change and make a number of necessary technical amendments.

Code of governance for NHS provider trusts

The updated code of governance for NHS provider trusts came into effect from 1 April 2023 and replaces the 2014 NHS Foundation Trust Code of Governance.

The Code of Governance for NHS Provider Trusts sets out an overarching framework for the corporate governance of trusts, supporting delivery of effective corporate governance, understanding of statutory requirements where compliance is mandatory and provisions with which trusts must comply, or explain how the principles have been met in other ways.

The comply or explain approach gives trusts the Trust the flexibility to adopt alternative practices and explain how this continues to meet the principles of good governance in its annual report and accounts. The trust will comply or explain against the 2014 version of the code (NHS Foundation Trust Code of Governance) in its 2022/23 annual reports and accounts, and against the new code of governance for NHS provider trusts in its 2023/24 annual report and accounts.

What has changed in the new code

In general, the provisions of the code do not greatly differ from the 2014 version and the statutory roles and responsibilities of the Board of Directors have not changed. There are some underlying themes which are included for the first time.

- Requirement of the Board to assess the Trust's contribution to the objectives of the Integrated Care Partnership (ICP) and ICB as part of its assessment of its performance, with system partners highlighted as key stakeholders

- Inclusion of the Board's role in assessing and monitoring the culture of the organisation and taking corrective action as required and investing in, rewarding and promoting the wellbeing of its workforce
- New focus on equality, diversity and inclusion among Board members and training for those undertaking director-level recruitment. The Board should have a plan in place for the Board and senior management of the organisation to reflect the diversity of the local community and/or workforce
- Greater involvement for NHS England (NHSE) in recruitment and appointment processes for the Board and use of the NHSE remuneration structure for Chair and Non-Executive Director remuneration

Many provisions relating to Councils of Governors are now included in Appendix B rather than the body of the Code and the disclosures section. The role and responsibilities of Councils in law does not change with the new Act, so there is little to note save:

- The description of Councils of Governors' duty to represent the interests of the "**public at large**" is fleshed out: "this includes the population of the local system of which the Trust is part and the whole population of England as served by the wider NHS."
- A new suggestion that the Council may look at the nature of the Trust's "**collaboration with system partners**" as an indicator of organisational performance
- A clarification of the Council's role in relation to approving significant transactions, mergers and acquisitions so that "**to withhold its consent, the Council of Governors would need to provide evidence that due diligence was not undertaken**." This was always the intention of the governor role in this regard however this perhaps sets it out more explicitly than previous guidance

The deputy company secretary will undertake a detailed gap analysis of compliance against the new code of governance and findings will be reported to the Board at its public meeting on 4 May 2023.

Addendum to Your statutory duties: reference guide for NHS foundation trust governors

An addendum to Your statutory duties: a reference guide for NHS foundation trust governors has been issued, which supplements the guide rather than replacing it. The two documents should be read and used in conjunction. The addendum is based on the existing statutory duties as set out in the 2006 Act and there are no changes to these. Governors' powers and duties remain the same. The addendum is designed to add clarity and reflect changes in the structures of the NHS.

The addendum:

- Explains how the legal duties of Foundation Trust Councils of Governors should support system working and collaboration. Council of Governors are now required to form a rounded view of the interests of the 'public at large'

- Introduces the context of system working following the introduction of the Health and Care Act 2022 and the removal of legal barriers to collaboration and integrated care. The performance of NHS provider trusts will increasingly be judged against their contribution to the objectives of their ICS. It also goes into some detail on what representing the interests of the public means in the new context, emphasising that 'the public' should include the population of the local system of which the Foundation Trust is part

- Focuses on the statutory duties of Governors and additional considerations in relation to each: holding the NEDs to account for the performance of the board; representing the interests of members and public; and taking decisions on significant transactions. Illustrative scenarios are provided in each case including advice for trusts which provide specialist services

- Suggests approaches to support better working between the Board and Council, with some practical tips and examples of activities trusts are already undertaking. It emphasises that Governors' key relationships remain with the Directors and the Secretary of their own Trust, who should facilitate information sharing about, and any engagement with, system partners

Recommendation
Council is asked to **note** the contents of the report.

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Code of governance for NHS provider trusts

Publication (/publication)

Content

Equality and health inequalities statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

About this document

This code sets out a common overarching framework for the corporate governance of trusts, reflecting developments in UK corporate governance and the development of integrated care systems.

Key points

- Corporate governance is the means by which boards lead and direct their organisations so that decision-making is effective, risk is managed and the right outcomes are delivered.
- In the NHS this means delivering high quality services in a caring and compassionate environment while collaborating through system and place-based partnerships and provider collaboratives to integrate care.
- Best practice is detailed in the following sections: board leadership and purpose, division of responsibilities, composition, succession and evaluation, audit, risk, internal control and remuneration.

Action required

- Trusts must comply with each of the provisions of the code or, where appropriate, explain in each case why the trust has departed from the code.

Other guidance and resources

- Integrated care systems: design framework (https://www.england.nhs.uk/publication/integrated-care-systems-design-framework/)
- Working together at scale: guidance on provider collaboratives (https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf)
- The wider suite of Integrated care systems: guidance (https://www.england.nhs.uk/publication/integrated-care-systems-guidance/)

Privacy - Terms

Introduction

1. Why is there a Code of Governance?

1.1 NHS England has issued this Code of Governance (the code) to help NHS providers deliver effective corporate governance, contribute to better organisational and system performance and improvement, and ultimately discharge their duties in the best interests of patients, service users and the public.

1.2 The board of directors is a unitary board. This means that within the board of directors, the non-executive directors and executive directors make decisions as a single group and share the same responsibility and liability. All directors, executive and non-executive, have responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.

1.3 In this code, we bring together the best practices of the NHS and private sector. We set out a common overarching framework for the corporate governance of trusts that complements the statutory and regulatory obligations they have (these are referenced throughout this document).

1.4 As with the UK Corporate Governance Code, each section of this code is built around a set of principles emphasising the value of good corporate governance to long-term sustainable success. Each section also incorporates a set of more detailed provisions to implement these, which can help trusts demonstrate the effectiveness of governance practices and their contribution to the long-term success of the organisation and its wider system.

2. What is new about this version of the code?

2.1 This version of the code applies from April 2023. A great deal has changed since we last updated the code in 2014. NHS England, Monitor and the NHS Trust Development Authority (TDA) started formally working together on 1 April 2019 to provide better support to delivery of the NHS Long Term Plan (https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/) (January 2019), which set the direction for greater integration of care with providers collaborating with partners in health and care systems. All systems had achieved integrated care system (ICS) status by April 2021. The Health and Care Act 2022 has merged Monitor and the TDA into NHS England and removed legal barriers to collaboration and integrated care, making it easier for providers to take on greater responsibility for service planning and putting ICSs on a statutory footing through establishing for each ICS:

- An integrated care partnership (ICP), a statutory joint committee of the integrated care board (ICB) and the upper tier local authorities in the ICS, that brings together organisations and representatives concerned with improving the care, health and wellbeing of the population. Each partnership has been established by the NHS and local government as equal partners and has a duty to develop an integrated care strategy proposing how the NHS and local government should exercise their functions to integrate health and care and address the needs of the population identified in the local joint strategic needs assessment(s).
- An ICB, which brings the NHS together locally, to improve population health and care; its unitary board allocates NHS budget and commissions services, and – having regard to the ICP's integrated care strategy – produces a five-year joint plan for health services and annual capital plan agreed with its partner NHS trusts and NHS foundation trusts.

2.2 The ICP and ICB, together with other key elements of the new arrangements including place-based partnerships and provider collaboratives, are tasked with bringing together all partners within an ICS.

2.3 At the heart of effective collaboration is the expectation that providers will work effectively on all issues, including those that may be contentious for the organisation and system partners, rather than focusing only on those issues for which there is already a clear way forward or which are perceived to benefit their organisation. The success of individual NHS trusts and foundation trusts will increasingly be judged against their contribution to the objectives of the ICS, in addition to their existing duties to deliver high quality care and effective use of resources (Integrated care systems: design framework (https://www.england.nhs.uk/wp-content/uploads/2021/06/B0642-ics-design-framework-june-2021.pdf), p30).

2.4 To support this shift, we have put in place a new single framework for overseeing NHS systems and organisations, the NHS Oversight Framework (https://www.england.nhs.uk/nhs-oversight-framework/), which will evolve particularly for 2023/24. Under this new framework we intend to continue to treat providers in comparable circumstances similarly unless there is sound reason not to.

2.5 This updated code therefore applies to both NHS foundation trusts and, for the first time, NHS trusts. NHS foundation trusts and NHS trusts are constituted differently.

- NHS foundation trusts are public benefit corporations and their boards of directors have a framework of local accountability through members and a council of governors. The NHS foundation trust council of governors is responsible for holding the non-executive directors individually and collectively to account. In turn, NHS foundation trust governors are accountable to the members who elect them and must represent their interests and the interests of the public.

- NHS trusts were established by orders of the Secretary of State for Health and Social Care. Their chairs and non-executive directors are appointed by NHS England (chairs and non-executive directors hold a statutory office under the National Health Service Act 2006. The appointment and tenure of office are governed by the NHS Trusts (Membership and Procedure) Regulations 1990. NHS England makes NHS trust chair and non-executive director appointments using powers delegated by the Secretary of State for Health and Social Care. Board appointments are regulated by the Commissioner for Public Appointments to provide independent assurance that they are made in accordance with government's Principles of Public Appointments and Governance Code for public bodies) and they do not have a council of governors or members. Instead, we have a duty to hold the chair and non-executive directors of NHS trusts individually and collectively to account for the performance of the board.

2.6 Despite their different constitutions, there are overarching principles of corporate governance that apply to both NHS trusts and NHS foundation trusts. Where particular provisions of the code apply only to NHS foundation trusts or NHS trusts, we explicitly indicate this. Where we refer to 'trusts' in this code, we mean both NHS trusts and NHS foundation trusts. We use the term 'chief executive' to apply to the chief executives of NHS foundation trusts and the chief officers of NHS trusts, except in sections that are specific to NHS trusts, where we use 'chief officer'. References to 'directors' include the chair, executive and non-executive directors.

2.7 The UK Corporate Governance Code, on which the code has always been based, has also been updated a number of times since 2014. This code is modelled on the 2018 version of the UK Corporate Governance Code (https://www.frc.org.uk/directors/corporate-governance-and-stewardship/uk-corporate-governance-code).

3. What is corporate governance?

3.1 A trust board needs to be able to deliver entrepreneurial and effective leadership and prudent and effective oversight of the trust's operations, to ensure it is operating in the best interests of patients, service users and the public.

3.2 Corporate governance is the means by which boards lead and direct their organisations so that decision-making is effective, risk is managed and the right outcomes are delivered. In the NHS this means delivering high quality services in a caring and compassionate environment, while collaborating within ICSs to integrate care and complying with the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources. Robust governance structures that support collaborative leadership and relationships with system partners and other stakeholders, and strong local accountability will help trusts maintain the trust and confidence of the people and communities they service. Good corporate governance is dynamic. Boards should be committed to improving governance on a continuing basis through evaluation and review.

3.3 Robust corporate and quality governance arrangements complement and reinforce one another. Quality governance is the combination of structures and processes at and below board level to lead on trust-wide quality performance, including (i) ensuring required standards are achieved and (ii) investigating and acting on sub-standard performance. Clinicians are at the frontline of ensuring patients receive quality care. However, the board of directors takes final and definitive responsibility for improvements, successful delivery and, equally, failures in the quality of care. Effective governance therefore requires boards to pay as much attention to quality of care and quality governance as they do to the financial health of their organisation. Boards also set the tone of their organisation by demonstrating shared values and behaviours, and recognising their organisation's role in an ICS and the wider NHS, and the risks and opportunities this may present for quality of care. Further guidance can be found in the Well-led framework for le (https://www.england.nhs.uk/well-led-framework/)adership and governance developmental reviews.

4. What should trusts do to fulfil the code's requirements of good governance?

4.1 We seek to support good governance by offering sound guidance. We are keen that trusts have the flexibility to ensure their structures and processes work well now and in the future, while making sure they meet the code's overall requirements for good governance, which are designed with the interests of patients, service users and the public in mind.

4.2 Ultimately only directors can demonstrate and promote the board behaviour needed to guarantee good corporate governance in practice. Good governance requires continuing and determined effort and boards have opportunities within the framework of the code to decide themselves how they should act.

Comply or explain

4.3 The provisions of the code, as best practice advice, do not represent mandatory guidance and accordingly non-compliance is not in itself a breach of Condition FT4 of the NHS provider licence (also known as the governance condition; NHS England has deemed it appropriate that Condition FT4 applies to NHS trusts as well as NHS foundation trusts under it's "shadow" licence regime). However, non-compliance may form part of a wider regulatory assessment on adherence to the provider licence.

4.4 Satisfactory engagement between the board of directors, the council of governors and members of foundation trusts, and patients, service users and the public is crucial to the effectiveness of trusts' corporate governance approach. Directors and, for foundation trusts, governors both have a responsibility for ensuring that 'comply or explain' remains an effective basis for this code.

Disclosure requirements

4.5 To meet the requirements of 'comply or explain' each trust must comply with each of the provisions of the code (which in some cases will require a statement or information in the annual report, or provision of information to the public or, for foundation trusts, governors or members) or, where appropriate, explain in each case why the trust has departed from the code.

4.6 We recognise that departure from the specific provisions of the code may be justified in particular circumstances. Reasons for non-compliance with the code should be explained, with the trust illustrating how its actual practices are consistent with the principle to which the particular provision relates. It should set out the background, provide a clear rationale and describe any mitigating actions it is taking to address any risks and maintain conformity with the relevant principle. Where deviation from a particular provision is intended to be limited in time, the trust should indicate when it expects to conform to the provision.

4.7 The form and content of this part of the statement are not prescribed, the intention being that trusts should have a free hand to explain their governance policies in the light of the principles, including any special circumstances applying to them which have led to a particular approach.

4.8 It is important to note that:

- Some provisions require a statement or information in the annual report. Where information would otherwise be duplicated, trusts need only provide a clear reference to the location of the information within their annual report.
- Other provisions require a trust to make information publicly available or, for foundation trusts, to provide information to their governors or members.
- The remaining provisions are those for which 'comply or explain' applies.
- Schedule A of the code sets out which provisions fall into which category.

5. How does the code fit with other NHS England requirements?

5.1 Although compliance with the provisions in this code is on a 'comply or explain' basis, we have included and clearly identified in the code any relevant statutory requirements. In the first instance, boards, directors and, for foundation trusts, governors should ensure they are meeting the specific governance requirements set out in the NHS provider licence (https://www.england.nhs.uk/licensing-and-oversight-of-independent-providers/licensing/#who-needs-a-licence).

5.2 The code sits alongside other NHS England reporting requirements which relate to governance but do not conflict or connect with the code. The code also includes references to other NHS England publications that focus on audit and internal control:

- NHS foundation trust annual reporting manual (https://www.england.nhs.uk/financial-accounting-and-reporting/nhs-foundation-trust-annual-reporting-manual/).

5.3 For clarity, we have provided a detailed explanation of how the different requirements sit together and the purpose of each in Appendix C.

6. Further information

6.1 Trusts may also find it useful to consult other guidance and sources of best practice about governance of public bodies and the NHS. In particular, the following publications are likely to be useful when considered alongside the code:

- Developmental reviews of leadership and governance using the well-led framework: guidance for NHS trusts and NHS foundation trusts (https://www.england.nhs.uk/well-led-framework/)
- Guidance on good governance and collaboration under the NHS provider licence (https://www.england.nhs.uk/long-read/guidance-on-good-governance-and-collaboration/)
- Your statutory duties: A reference guide for NHS foundation trust governors (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/284473/Governors_g
- Foundation trust councils of governors and system working and collaboration: An addendum to your statutory duties – A reference guide for NHS foundation trust governors (https://www.england.nhs.uk/long-read/addendum-to-your-statutory-duties--reference-guide-for-nhs-foundation-trust-governors/)
- Director-governor interaction in NHS foundation trusts: A best practice guide for boards of directors (https://www.gov.uk/government/publications/nhs-foundation-trust-governors-and-directors-working-better-together)

- The Healthy NHS Board 2013 – Principles for good governance (https://www.leadershipacademy.nhs.uk/wp-content/uploads/2013/06/NHSLeadership-HealthyNHSBoard-2013.pdf)
- The seven principles of public life (https://www.gov.uk/government/publications/the-7-principles-of-public-life): covers the standards of behaviour in and principles of public
- Board governance essentials: a guide for chairs and boards of public bodies (https://www.cipfa.org/policy-and-guidance/publications/b/board-governance-essentials-a-guide-for-chairs-and-boards-of-public-bodies): developed by CIPFA (the Chartered Institute of Public Finance Accountants), this guide gives advice on the roles of chairs and board members.

Section A: Board leadership and purpose

1. Principles

1.1 Every trust should be led by an effective and diverse board that is innovative and flexible, and whose role it is to promote the long-term sustainability of the trust as part of the ICS and wider healthcare system in England, generating value for members in the case of foundation trusts, and for all trusts, patients, service users and the public.

1.2 The board of directors should establish the trust's vision, values and strategy, ensuring alignment with the ICP's integrated care strategy and ensuring decision-making complies with the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources. The board of directors must satisfy itself that the trust's vision, values and culture are aligned. All directors must act with integrity, lead by example and promote the desired culture.

1.3 The board of directors should give particular attention to the trust's role in reducing health inequalities in access, experience and outcomes.

1.4 The board of directors should ensure that the necessary resources are in place for the trust to meet its objectives, including the trust's contribution to the objectives set out in the five-year joint plan and annual capital plan agreed by the ICB and its partners, and measure performance against them. The board of directors should also establish a framework of prudent and effective controls that enable risk to be assessed and managed. For their part, all board members – and in particular non-executives whose time may be constrained – should ensure they collectively have sufficient time and resource to carry out their functions.

1.5 For the trust to meet its responsibilities to stakeholders, including patients, staff, the community and system partners, the board of directors should ensure effective engagement with them, and encourage collaborative working at all levels with system partners.

1.6 The board of directors should ensure that workforce policies and practices are consistent with the trust's values and support its long-term sustainability. The workforce should be able to raise any matters of concern. The board is responsible for ensuring effective workforce planning aimed at delivering high quality of care.

2. Provisions

2.1 The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.

2.2 The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place-based partnerships, and provider collaboratives. This should be a formally agreed statement of the organisation's purpose and intended outcomes, and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners and other decisions.

2.3 The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.

2.4 The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five-year joint plan for health services and annual capital plan agreed by the ICB and its partners (This may also include working to deliver the financial duties and objectives the trust is collectively responsible for with ICB partners, and improving quality and outcomes and reducing unwarranted variation and inequalities across the system), and that risk

is managed effectively. The board should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.

2.5 In line with principle 1.3 above, the board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance, ensuring performance reports are disaggregated by ethnicity and deprivation where relevant. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, eg from the internal audit function, to provide an adequate and reliable level of assurance.

2.6 The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered.

2.7 The chair and board should regularly engage with stakeholders, including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of all stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually. Provisions regarding the role of the council of governors in stakeholder engagement are contained in Appendix B.

2.8 The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective.

2.9 The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.

2.10 The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement (directors are required to declare any business interests, position of authority in a charity or voluntary body in the field of health and social care, and any connection with bodies contracting for NHS services. The trust must enter these into a register available to the public in line with Managing conflicts of interest in the NHS: Guidance for staff and organisations (https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf). In addition, NHS foundation trust directors have a statutory duty to manage conflicts of interest. In the case of NHS trusts, certain individuals are disqualified from being directors on the basis of conflicting interests).

2.11 Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board.

Section B: Division of responsibilities

1. Principles

1.1 The chair leads the board of directors and, for foundation trusts, the council of governors, and is responsible for its overall effectiveness in leading and directing the trust. They should demonstrate objective judgement throughout their tenure and promote a culture of honesty, openness, trust and debate. In addition, the chair facilitates constructive board relations and the effective contribution of all non-executive directors, and ensures that directors and, for foundation trusts, governors receive accurate, timely and clear information.

1.2 Responsibilities should be clearly divided between the leadership of the board and the executive leadership of the trust's operations. No individual should have unfettered powers of decision.

1.3 Non-executive directors should have sufficient time to meet their board responsibilities. They should provide constructive challenge and strategic guidance, offer specialist advice and lead in holding the executive to account.

1.4 The board of directors should ensure that it has the policies, processes, information, time and resources it needs to function effectively, efficiently and economically.

1.5 The board is collectively responsible for the performance of the trust.

1.6 The board of directors as a whole is responsible for ensuring the quality and safety of the healthcare services, education, training and research delivered by the trust, and applying the principles and standards of clinical governance set out by DHSC, NHS England, the CQC and other relevant NHS bodies.

1.7 All members of the board of directors have joint responsibility for every board decision regardless of their individual skills or status. This does not impact on the particular responsibilities of the chief executive as the accounting officer.

2. Provisions

2.1 The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.

2.2 The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role.

2.3 The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular, and ensuring a constructive relationship between executive and non-executive directors.

2.4 A foundation trust chair is responsible for ensuring that the board and council work together effectively.

2.5 The chair should be independent on appointment when assessed against the criteria set out in provision 2.6 below. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.

2.6 The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances that are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director:

- has been an employee of the trust within the last two years
- has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, material shareholder, director or senior employee of a body that has such a relationship with the trust
- has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme
- has close family ties with any of the trust's advisers, directors or senior employees
- holds cross-directorships or has significant links with other directors through involvement with other companies or bodies
- has served on the trust board for more than six years from the date of their first appointment (but note 4.3 in Section C below, where chairs and NEDs can serve beyond six years subject to rigorous review and NHS England approval).
- is an appointed representative of the trust's university medical or dental school.

Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.

2.7 At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.

2.8 No individual should hold the positions of director and governor of any NHS foundation trust at the same time.

2.9 The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees. For foundation trusts, the council of governors should take into account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a range of skill sets, backgrounds and lived experience.

2.10 Only the committee chair and committee members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.

2.11 In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on

other occasions as necessary, and seek input from other key stakeholders. For NHS trusts the process is the same but the appraisal is overseen by NHS England as set out in the Chair appraisal framework (https://www.england.nhs.uk/non-executive-opportunities/chair-non-executives-support/framework-conducting-annual-appraisals-nhs-provider-chairs/).

2.12 Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present.

2.13 The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available. The annual report should give the number of times the board and its committees met, and individual director attendance.

2.14 When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on material additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation.

2.15 All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.

2.16 All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, request further information if necessary, and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.

2.17 The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions. For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions that are delegated to the executive management of the board of directors.

Section C: Composition, succession and evaluation

1. Principles

1.1 Appointments to the board of directors should follow a formal, rigorous and transparent procedure, and an effective succession plan should be maintained for board and senior management. Appointments should be made solely in the public interest, with decisions based on integrity, merit, openness and fairness. Both appointments and succession plans should be based on merit and objective criteria and, within this context, should promote diversity of gender, social and ethnic backgrounds, disability, and cognitive and personal strengths (for more information refer to the Equality Act 2010, The NHS' successive Equality Delivery Systems (EDS) and the NHS Workforce Race Equality Standard (WRES)). In particular, the board should have published plans for how it and senior managers will in percentage terms at least match the overall black and minority composition of its overall workforce, or its local community, whichever is the higher.

1.2 The board of directors and its committees should have a diversity of skills, experience and knowledge. The board should be of sufficient size for the requirements of its duties, but should not be so large as to be unwieldy. Consideration should be given to the length of service of the board of directors as a whole and membership regularly refreshed.

1.3. Annual evaluation of the board of directors should consider its composition, diversity and how effectively members work together to achieve objectives. Individual evaluation should demonstrate whether each director continues to contribute effectively.

2. Provisions for NHS foundation trusts board appointments

2.1 The nominations committee or committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust, and

the skills and expertise required within the board of directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from a relevant ICB, and the foundation trust should engage with NHS England to agree the approach.

2.2 There may be one or two nominations committees. If there are two, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chair). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and recommend changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the board of directors and, in the light of this evaluation, describe the role and capabilities required for appointment of both executive and non-executive directors, including the chair.

2.3 The chair or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chair.

2.4 The governors should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the nominations committee should make recommendations to the council of governors.

2.5 Open advertising and advice from NHS England's Non-Executive Talent and Appointments team is available for use by nominations committees to support the council of governors in the appointment of the chair and non-executive directors. If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.

2.6 Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should have governors and/or independent members in the majority. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chair or a deputy chair, are being discussed, governors and/or independent members should be in the majority on the committee and also on the interview panel.

2.7 When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.

2.8 The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.

2.9 Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information.

Relevant statutory requirements

2.10 A requirement of the National Health Service Act 2006 as amended (the 2006 Act) is that the chair, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive are responsible for deciding the appointment of executive directors. The nominations committee with responsibility for executive director nominations should identify suitable candidates to fill executive director vacancies as they arise and make recommendations to the chair, the other non-executives directors and, except in the case of the appointment of a chief executive, the chief executive.

2.11 It is for the non-executive directors to appoint and remove the chief executive. The appointment of a chief executive requires the approval of the council of governors.

2.12 The governors are responsible at a general meeting for the appointment, re-appointment and removal of the chair and other non-executive directors.

2.13 Non-executive directors, including the chair, should be appointed by the council of governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provisions relating to removal of a director.

2.14 The terms and conditions of appointment of non-executive directors should be made available to the council of governors. The letter of appointment should set out the expected time commitment. Non-executive directors should undertake that they will have sufficient time to do what is expected of them. Their other significant commitments should be disclosed to the council of governors before appointment, with a broad indication of the time involved, and the council of governors should be informed of subsequent changes.

3. Provisions for NHS trust board appointments

3.1 NHS England is responsible for appointing chairs and other non-executive directors of NHS trusts. A committee consisting of the chair and non-executive directors is responsible for appointing the chief officer of the trust. A committee consisting of the chair, non-executive directors and the chief officer is responsible for appointing the other executive directors. NHS England has a key advisory role in ensuring the integrity, rigour and fairness of executive appointments at NHS trusts. The selection panel for the posts should include at least one external assessor from NHS England.

4. Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts

4.1 Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors (https://www.cqc.org.uk/guidance-providers/regulations-enforcement/fit-proper-persons-directors).

4.2 The board of directors should include in the annual report a description of each director's skills, expertise and experience. Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.

4.3 Chairs or NEDs should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment a chair was an existing non-executive director. The need for all extensions should be clearly explained and should have been agreed with NHS England. A NED becoming chair after a three-year term as a non-executive director would not trigger a review after three years in post as chair.

4.4 Elected foundation trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The governor names submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.

4.5 There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts.

4.6 The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.

4.7 All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework (https://www.england.nhs.uk/well-led-framework/) every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors or governors.

4.8 Led by the chair, foundation trust councils of governors should periodically assess their collective performance and regularly communicate to members and the public how they have discharged their responsibilities, including their impact and effectiveness on:

- holding the non-executive directors individually and collectively to account for the performance of the board of directors
- communicating with their member constituencies and the public and transmitting their views to the board of directors
- contributing to the development of the foundation trust's forward plans.

The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Your statutory duties: a reference guide for NHS foundation trust governors (https://www.gov.uk/government/publications/nhs-foundation-trust-governors-your-legal-obligations) and an Addendum to Your statutory duties – A reference guide for NHS foundation trust governors (https://www.england.nhs.uk/long-read/addendum-to-your-statutory-duties--reference-guide-for-nhs-foundation-trust-governors/).

4.9 The council of governors should agree and adopt a clear policy and a fair process for the removal of any governor who consistently and unjustifiably fails to attend its meetings or has an actual or potential conflict of interest that prevents the proper exercise of their duties. This should be shared with governors.

4.10 In addition, it may be appropriate for the process to provide for removal from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust. NHS England's model core constitution suggests that a governor can be removed by a 75% voting majority; however, trusts are free to stipulate a lower threshold if considered appropriate. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable. NHS England can only use its enforcement powers to require a trust to remove a governor in very limited circumstances: where it has imposed an additional condition relating to governance in the trust's licence because the governance of the trust is such that the trust would otherwise fail to comply with its licence and the trust has breached or is breaching that additional condition. It is more likely that NHS England would have cause to require a trust to remove a director under its enforcement powers than a governor.

4.11 The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.

4.12 The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.

4.13 The annual report should describe the work of the nominations committee(s), including:

- the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline
- how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors, governors and individual directors, the outcomes and actions taken, and how these have or will influence board composition
- the policy on diversity and inclusion, including in relation to disability, its objectives and linkage to trust strategy, how it has been implemented and progress on achieving the objectives
- the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard (https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/) and how far the board reflects the ethnic diversity of the trust's workforce and communities served
- the gender balance of senior management and their direct reports.

5. Development, information and support

5.1 All directors and, for foundation trusts, governors should receive appropriate induction on joining the board of directors or the council of governors, and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.

5.2 The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. Directors should also be familiar with the integrated care system(s) that commission material levels of services from the trust. The trust should provide the necessary resources for its directors and, for foundation trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training, including on equality, diversity and inclusion, and unconscious bias.

5.3 To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors and governors also need to be appropriately briefed on values and all policies and procedures adopted by the trust.

5.4 The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.

5.5 The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.

5.6 A foundation trust board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.

5.7 The board of directors and, for foundation trusts, the council of governors should be given relevant information in a timely manner, form and quality that enables them to discharge their respective duties. Foundation trust governors should be provided with information on ICS plans, decisions and delivery that directly affect the organisation and its patients. Statutory requirements on the provision of information from the foundation trust board of directors to the council of governors are provided in Your statutory duties: a reference guide for NHS foundation trust governors (https://www.gov.uk/government/publications/nhs-foundation-trust-governors-your-legal-obligations).

5.8 The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.

5.9 The chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors and their committees; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as facilitating appropriate induction and assisting with professional development as required.

5.10 The board of directors and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.

5.11 The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors, but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.

5.12 The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.

5.13 Committees should be provided with sufficient resources to undertake their duties. The board of directors of foundation trusts should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.

5.14 Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles.

5.15 Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.

5.16 Where appropriate, the board of directors should in a timely manner take account of the views of the council of governors on the forward plan, and then inform the council of governors which of their views have been incorporated in the NHS foundation trust's plans, and explain the reasons for any not being included.

Relevant statutory requirements

5.16 The board of directors must have regard to the council of governors' views on the NHS foundation trust's forward plan.

Insurance cover

5.17 NHS Resolution's Liabilities to Third Parties Scheme (https://resolution.nhs.uk/wp-content/uploads/2018/09/LTPS-Rules.pdf) includes liability cover for trusts' directors and officers. Assuming foundation trust governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.

Section D: Audit, risk and internal control

1. Principles

1.1 The board of directors should establish formal and transparent policies and procedures to ensure the independence and effectiveness of internal and external audit functions, and satisfy itself on the integrity of financial and narrative statements.

1.2 The board of directors should present a fair, balanced and understandable assessment of the trust's position and prospects.

1.3 The board of directors should establish procedures to manage risk, oversee the internal control framework, and determine the nature and extent of the principal risks the trust is willing to take to achieve its long-term strategic objectives.

1.4 Organisations should also refer to Audit and assurance: a guide to governance for providers and commissioners (https://www.england.nhs.uk/financial-accounting-and-reporting/audit-and-assurance-a-guide-to-governance/).

2. Provisions

2.1 The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a whole should have competence relevant to the sector in which the trust operates.

2.2 The main roles and responsibilities of the audit committee should include:

- monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them
- providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy
- reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself
- monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors
- reviewing and monitoring the external auditor's independence and objectivity
- reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements
- reporting to the board of directors on how it has discharged its responsibilities.

2.3 A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should re-tender its external audit at least every 10 years and in most cases more frequently than this. These timeframes are not affected by an NHS trust becoming a foundation trust.

2.4 The annual report should include:

- the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed
- an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans
- an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.

2.5 Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services. The council of governors is responsible for appointing external governors.

2.6 The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.

2.7 The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.

2.8 The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.

2.9 In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual (https://www.england.nhs.uk/financial-accounting-and-reporting/nhs-foundation-trust-annual-reporting-manual/), which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over a going concern are expected to be rare.

Section E: Remuneration

1. Principles

1.1 Levels of remuneration should be sufficient to attract, retain and motivate directors of quality, with the skills and experience required to lead the trust successfully, and collaborate effectively with system partners. Trusts should avoid paying more than is necessary for this purpose and should consider all relevant and current directions relating to contractual benefits such as pay and redundancy entitlements. Trusts should follow NHS England's Guidance on pay for very senior managers in NHS trusts and foundation trusts (https://www.england.nhs.uk/publication/guidance-on-pay-for-very-senior-managers/) and NHS trusts should also follow Guidance on senior appointments in NHS trusts (https://www.england.nhs.uk/wp-content/uploads/2021/11/Guidance-on-senior-appointments-in-NHS-trusts.pdf).

1.2 Any performance-related elements of executive directors' remuneration should be transparent, stretching and designed to promote the long-term sustainability of the NHS foundation trust. They should also take as a baseline for performance any required competencies specified in the job description for the post.

1.3 The remuneration committee should decide if a proportion of executive directors' remuneration should be linked to corporate and individual performance. The remuneration committee should judge where to position its NHS foundation trust relative to other NHS foundation trusts and comparable organisations. Such comparisons should be used with caution to avoid any risk of an increase in remuneration despite no corresponding improvement in performance.

1.4 The remuneration committee should also be sensitive to pay and employment conditions elsewhere in the NHS, especially when determining annual salary increases.

1.5 There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding their own remuneration.

1.6 The remuneration committee should take care to recognise and manage conflicts of interest when receiving views from executive directors or senior management, or consulting the chief executive about its proposals (for further information on conflicts of interest see Managing conflicts of interest in the NHS: Guidance for staff and organisations (https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf)).

1.7 The remuneration committee should also be responsible for appointing any independent consultants in respect of executive director remuneration.

1.8 Where executive directors or senior management are involved in advising or supporting the remuneration committee, care should be taken to recognise and avoid conflicts of interest.

1.9 NHS trusts should wait for notification and instruction from NHS England before implementing any cost of living increases.

2. Provisions

2.1 Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions.

- Whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients.
- Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the trust. Consideration should be given to criteria that reflect the performance of the trust against some key indicators and relative to a group of comparator trusts, and the taking of independent and expert advice where appropriate.

- Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed, and must be limited to the lower of £17,500 or 10% of basic salary.
- For NHS foundation trusts, non-executive terms and conditions are set by the trust's council of governors.
- The remuneration committee should consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.

2.2 Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure (https://www.england.nhs.uk/non-executive-opportunities/about-the-team/remuneration-structure-nhs-provider-chairs-and-non-executive-directors/).

2.3 Where a trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.

2.4 The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered where a director returns to the NHS within the period of any putative notice.

2.5 Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity (severance payment includes any payment whether included in a settlement agreement or not, redundancy payment, a secondment arrangement, pay in lieu of notice, garden leave and pension enhancements).

2.6 The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.

2.7 The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The board should define senior management for this purpose and this should normally include the first layer of management below board level.

Relevant statutory requirements

2.8 The council of governors is responsible for setting the remuneration of a foundation trust's non-executive directors and the chair.

Schedule A: Disclosure of corporate governance arrangements

Trusts are required to provide a specific set of disclosures to meet the requirement of the Code of Governance. These should be submitted as part of the annual report (as set out for foundation trusts in the NHS foundation trust annual reporting manual (https://www.england.nhs.uk/financial-accounting-and-reporting/nhs-foundation-trust-annual-reporting-manual/) and for NHS trusts in DHSC group accounting manual.

The provisions listed below require a supporting explanation in a trust's annual report, even in the case that the trust is compliant with the provision. Where the information is already in the annual report, a reference to its location is sufficient to avoid unnecessary duplication.

Section A, 2.1

The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.

Section A, 2.3

The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's

approach to investing in, rewarding and promoting the wellbeing of its workforce.

Section A, 2.8

The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.

Section B, 2.6

The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director:

- has been an employee of the trust within the last two years
- has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust
- has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme
- has close family ties with any of the trust's advisers, directors or senior employees
- holds cross-directorships or has significant links with other directors through involvement with other companies or bodies
- has served on the trust board for more than six years from the date of their first appointment
- is an appointed representative of the trust's university medical or dental school.

Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.

Section B, 2.13

The annual report should give the number of times the board and its committees met, and individual director attendance.

Section B, 2.17 (NHS foundation trusts only)

For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.

Section C, 2.5 (NHS foundation trusts only)

If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.

Section C, 2.8 (NHS foundation trusts only)

The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.

Section C, 4.2

The board of directors should include in the annual report a description of each director's skills, expertise and experience.

Section C, 4.7

All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.

Section C, 4.13

The annual report should describe the work of the nominations committee(s), including:

- the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline
- how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition
- the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives
- the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served
- the gender balance of senior management and their direct reports.

Section C, 5.15 (NHS foundation trusts only)

Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.

Section D, 2.4

The annual report should include:

- the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed
- an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans
- where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit

an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.

Section D, 2.6

The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.

Section D, 2.7

The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.

Section D, 2.8

The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.

Section D, 2.9

In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the *DHSC group accounting manual* and *NHS foundation trust annual reporting manual* which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.

Section E, 2.3

Where a trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.

For the provisions listed below, **the basic 'comply or explain' requirement applies**. The disclosure in the annual report should therefore contain an explanation in each case where the trust has departed from the code, explaining the reasons for the departure and how the alternative arrangements continue to reflect the principles of the code. Trusts are welcome but not required to provide a simple statement of compliance with each individual provision. This may be useful in ensuring the disclosure is comprehensive and may help to ensure that each provision has been considered in turn. In providing an explanation for any variation from the code, the trust should aim to illustrate how its actual practices are consistent with the principles to which the particular provision relates. It should set out the background, provide a clear rationale, and describe any mitigating actions it is taking to address any risks and maintain conformity with the relevant principle. Where deviation from a particular provision is intended to be limited in time, the explanation should indicate when the trust expects to conform to the provision.

Section A, 2.2

The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place-based partnerships, and provider collaboratives. This should be a formally agreed statement of the organisation's purpose and intended outcomes and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners, and other decisions.

Section A, 2.4

The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five-year joint plan for health services and annual capital plan agreed by the ICB and its partners, and to ensure that risk is managed effectively. The board should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.

Section A, 2.5

The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, eg from the internal audit function, to provide an adequate and reliable level of assurance.

Section A, 2.6

The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered.

Section A, 2.7

The chair should regularly engage with stakeholders including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of the stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually. Provisions regarding the role of the council of governors in stakeholder engagement are contained in Appendix B.

Section A, 2.9

The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.

Section A, 2.10

The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement.

Section A, 2.11

Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board.

Section B, 2.1

The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.

Section B, 2.2

The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role.

Section B, 2.3

The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular, and ensuring a constructive relationship between executive and non-executive directors.

Section B, 2.4 (NHS foundation trusts only)

A foundation trust chair is responsible for ensuring that the board and council work together effectively.

Section B, 2.5

The chair should be independent on appointment when assessed against the criteria set out in Section B, provision 2.6. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.

Section B, 2.7

At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.

Section B, 2.8

No individual should hold the positions of director and governor of any NHS foundation trust at the same time.

Section B, 2.9

The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees. For foundation trusts, the council of governors should take into account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a range of skill sets, backgrounds and lived experience.

Section B, 2.10

Only the committee chair and members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.

Section B, 2.11

In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders. For NHS trusts the process is the same but the appraisal is overseen by NHS England as set out in the chair appraisal framework.

Section B, 2.12

Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present.

Section B, 2.14

When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation.

Section B, 2.15

All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.

Section B, 2.16

The board of directors as a whole is responsible for ensuring the quality and safety of the healthcare services, education, training and research delivered by the trust and applying the principles and standards of clinical governance set out by DHSC, NHS England, the CQC and other relevant NHS bodies.

Section B, 2.17

All members of the board of directors have joint responsibility for every board decision regardless of their individual skills or status. This does not impact on the particular responsibilities of the chief executive as the accounting officer.

Section B, 2.16

All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.

Section B, 2.17

The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions.

Section C, 2.1 (NHS foundation trusts only)

The nominations committee or committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust and the skills and expertise required within the board of directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from the ICB, and the foundation trust should engage with NHS England to agree the approach.

Section C, 2.2 (NHS foundation trusts only)

There may be one or two nominations committees. If there are two committees, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chair). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and recommend changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the board of directors and, in the light of this evaluation, describe the role and capabilities required for appointment of both executive and non-executive directors, including the chair.

Section C, 2.3 (NHS foundation trusts only)

The chair or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chair.

Section C, 2.4 (NHS foundation trusts only)

The governors should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the nominations committee should make recommendations to the council of governors.

Section C, 2.5 (NHS foundation trusts only)

Open advertising and advice from NHS England's Non-Executive Talent and Appointments team should generally be used for the appointment of the chair and non-executive directors.

Section C, 2.6 (NHS foundation trusts only)

Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should have governors and/or independent members in the majority. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chair or a deputy chair, are being discussed, governors and/or independent members should be in the majority on the committee and also on the interview panel.

Section C, 2.7 (NHS foundation trusts only)

When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.

Section C, 3.1 (NHS trusts only)

NHS England is responsible for appointing chairs and other non-executive directors of NHS trusts. A committee consisting of the chair and non-executive directors is responsible for appointing the chief officer of the trust. A committee consisting of the chair, non-executive directors and the chief officer is responsible for appointing the other executive directors. NHS England has a key advisory role in ensuring the integrity, rigour and fairness of executive appointments at NHS trusts. The selection panel for the posts should include at least one external assessor from NHS England.

Section C, 4.1

Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation

to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.

Section C, 4.3

The chair should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment the chair was an existing non-executive director. The need for extension should be clearly explained and should have been agreed with NHS England.

Section C, 4.4 (NHS foundation trusts only)

Elected foundation trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The governor names submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.

Section C, 4.5

There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts. NHS foundation trusts and NHS trusts should make use of NHS Leadership Competency Framework for board level leaders.

Section C, 4.6

The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.

Section C, 4.8 (NHS foundation trusts only)

Led by the chair, foundation trust councils of governors should periodically assess their collective performance and regularly communicate to members and the public how they have discharged their responsibilities, including their impact and effectiveness on:

- holding the non-executive directors individually and collectively to account for the performance of the board of directors
- communicating with their member constituencies and the public and transmitting their views to the board of directors
- contributing to the development of the foundation trust's forward plans.

The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Your statutory duties: a reference guide for NHS foundation trust governors and an Addendum to Your statutory duties – A reference guide for NHS foundation trust governors.

Section C, 4.10 (NHS foundation trusts only)

In addition, it may be appropriate for the process to provide for removal from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust. NHS England's model core constitution suggests that a governor can be removed by a 75% voting majority; however, trusts are free to stipulate a lower threshold if considered appropriate. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable. NHS England can only use its enforcement powers to require a trust to remove a governor in very limited circumstances: where they have imposed an additional condition relating to governance in the trust's licence because the governance of the trust is such that the trust would otherwise fail to comply with its licence and the trust has breached or is breaching that additional condition. It is more likely that NHS England would have cause to require a trust to remove a director under its enforcement powers than a governor.

Section C, 4.11

The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.

Section C, 4.12

The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.

Section C, 5.1

All directors and, for foundation trusts, governors should receive appropriate induction on joining the board of directors or the council of governors and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.

Section C, 5.2

The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. The trust should provide the necessary resources for its directors and, for foundation trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training including on equality diversity and inclusion, including unconscious bias.

Section C, 5.3

To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors and governors also need to be appropriately briefed on values and all policies and procedures adopted by the trust.

Section C, 5.4

The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.

Section C, 5.5

The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.

Section C, 5.6 (NHS foundation trusts only)

A foundation trust board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.

Section C, 5.8

The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.

Section C, 5.9

The chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors and their committees; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as facilitating appropriate induction and assisting with professional development as

required.

Section C, 5.10

The board of directors and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.

Section C, 5.11

The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors, but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.

Section C, 5.12

The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.

Section C, 5.13

Committees should be provided with sufficient resources to undertake their duties. The board of directors of foundation trusts should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.

Section C, 5.14

Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles.

Section C, 5.16 (NHS foundation trusts only)

Where appropriate, the board of directors should in a timely manner take account of the views of the council of governors on the forward plan, and then inform the council of governors which of their views have been incorporated in the NHS foundation trust's plans, and explain the reasons for any not being included.

Section C, 5.17

The trust should arrange appropriate insurance to cover the risk of legal action against its directors. Assuming foundation trust governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. Governors may have the benefit of an indemnity and/or insurance from the trust. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.

Section D, 2.1

The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a whole should have competence relevant to the sector in which the trust operates.

Section D, 2.2

The main roles and responsibilities of the audit committee should include:

- monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them
- providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy
- reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself
- monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors
- reviewing and monitoring the external auditor's independence and objectivity
- reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements
- reporting to the board of directors on how it has discharged its responsibilities.

Section D, 2.3

A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should re-tender its external audit at least every 10 years and in most cases more frequently than this.

Section D, 2.5

Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services.

Section E, 2.1

Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions.

- Whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients.
- Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the trust. Consideration should be given to criteria which reflect the performance of the trust against some key indicators and relative to a group of comparator trusts, and the taking of independent and expert advice where appropriate.
- Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed and must be limited to the lower of £17,500 or 10% of basic salary.
- The remuneration committee should consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement

Section E, 2.2

Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.

Section E, 2.4

The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.

Section E, 2.5

Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity.

Section E, 2.7

The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The board should define senior management for this purpose and this should normally include the first layer of management below board level.

The provisions listed below require information to be made **available to governors,** even in the case that the trust is compliant with the provision.

Section C, 4.9 (NHS foundation trusts only)

The council of governors should agree and adopt a clear policy and a fair process for the removal of any governor who consistently and unjustifiably fails to attend its meetings or has an actual or potential conflict of interest which prevents the proper exercise of their duties. This should be shared with governors.

Section C, 5.7 (NHS foundation trusts only)

The board of directors and, for foundation trusts, the council of governors should be given relevant information in a timely manner, form and quality that enables them to discharge their respective duties. Foundation trust governors should be provided with information on ICS plans, decisions and delivery that directly affect the organisation and its patients. Statutory requirements on the provision of information from the foundation trust board of directors to the council of governors are provided in Your statutory duties: a reference guide for NHS foundation trust governors.

The provisions listed below require supporting information to be made **available to members**, even in the case that the trust is compliant with the provision.

Section C, 2.9 (NHS foundation trusts only)

Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information.

The provisions listed below require information to be made **publicly available,** even in the case that the trust is compliant with the provision. This requirement can be met by making supporting information available on request.

Section B, 2.13

The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available.

Section C, 4.2

Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.

Section E, 2.6

The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.

Appendix A: Role of the trust secretary

The trust secretary has a significant role in the administration of corporate governance. In particular, the trust secretary would normally be expected to:

- ensure good information flows to the board of directors and its committees and between senior management, non-executive directors and the governors where relevant
- ensure that procedures of both the board of directors and the council of governors are complied with
- advise the board of directors and the council of governors (through the chair) on all governance matters
- be available to give advice and support to individual directors, particularly in relation to the induction of new directors and assistance with professional development.

Appendix B: Council of governors and role of the nominated lead governor

1. Principles

1.1 The powers and obligations of governors of NHS foundation trusts are set out in the 2006 Act, as amended by the 2012 Act. This appendix describes the relevant areas of the governors' role. In addition, *Your statutory duties: A reference guide for NHS foundation trust governors* (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/284473/Governors_guide_ (August 2013) examines how governors can deliver their duties and an addendum to this document, System working and collaboration: The role of foundation trust councils of governors (https://www.england.nhs.uk/long-read/addendum-to-your-statutory-duties--reference-guide-for-nhs-foundation-trust-governors/) (October 2022) clarifies how governors can continue to perform their duties within the context of system working.

1.2 The council of governors has a duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors. This includes ensuring the board of directors acts so that the foundation trust does not breach the conditions of its licence. It remains the responsibility of the board of directors to design and then implement agreed priorities, objectives and the overall strategy of the NHS foundation trust.

1.3 The council of governors is responsible for representing the interests of NHS foundation trust members, the public at large, and staff in the governance of the NHS foundation trust. Governors must act in the best interests of the NHS foundation trust and should adhere to its values and code of conduct.

1.4 To discharge their duty to represent the public, councils of governors are required to take account of the interests of the public at large. This includes the population of the local system of which the trust is part and the whole population of England as served by the wider NHS.

1.5 Governors are responsible for regularly feeding back information about the trust, its vision and its performance to members, the public at large, and the stakeholder organisations that either elected or appointed them. The trust should ensure governors have appropriate support to help them discharge this duty.

1.6 Governors should discuss and agree with the board of directors how they will undertake these and any additional roles, giving due consideration to the circumstances of the NHS foundation trust and the needs of the system and wider NHS and emerging best practice.

1.7 Governors should work closely with the board of directors and must be presented with, for consideration, the annual report and accounts and the annual plan at a general meeting. The governors must be consulted on the development of forward plans for the trust and any significant changes to the delivery of the trust's business plan.

1.8 Governors should use their voting rights to hold the non-executive directors individually and collectively to account and act in the best interest of patients, members and the public at large. If the council of governors does withhold consent for a major decision, it must justify its reasons to the chair and the other non-executive directors, bearing in mind that its decision is likely to have a range of consequences for the NHS foundation trust, the system and the wider NHS. The council of governors should take care to ensure that reasons are considered, factual and within the spirit of the Nolan principles.

2. Provisions

2.1 The council of governors should meet sufficiently regularly to discharge its duties. Typically the council of governors would be expected to meet as a full council at least four times a year. Governors should make every effort to attend these meetings. The NHS foundation trust should take appropriate steps to facilitate attendance.

2.2 The council of governors should not be so large as to be unwieldy. The council of governors should be of sufficient size for the requirements of its duties. The roles, structure, composition and procedures of the council of governors should be reviewed regularly.

2.3 The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor. A record should be kept of the number of meetings of the council and the attendance of individual governors and it should be made available to members on request.

2.4 The roles and responsibilities of the council of governors should be set out in a written document. This statement should include a clear explanation of the responsibilities of the council of governors towards members and other stakeholders and how governors will seek their views and keep them informed.

2.5 The chair is responsible for leadership of both the board of directors and the council of governors but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive and other executives and non-executives, as appropriate, to their meetings. In these meetings other members of the council of governors may ask the chair or their deputy, or any other relevant director present at the meeting, questions about the affairs of the NHS foundation trust.

2.6 The council of governors should establish a policy for engagement with the board of directors for those circumstances where they have concerns about the performance of the board of directors, compliance with the provider licence or other matters related to the overall wellbeing of the NHS foundation trust and its collaboration with system partners. The council of governors should input to the board's appointment of a senior independent director.

2.7 The council of governors should ensure its interaction and relationship with the board of directors is appropriate and effective, in particular, by agreeing the availability and timely communication of relevant information, discussion and the setting in advance of meeting agendas and, where possible, using clear, unambiguous language.

2.8 The council of governors should only exercise its power to remove the chair or any non-executive directors after exhausting all means of engagement with the board of directors. The council should raise any issues with the chair with the senior independent director in the first instance.

2.9 The council of governors should receive and consider other appropriate information required to enable it to discharge its duties, eg clinical statistical data and operational data.

2.10 The chair (and the senior independent director and other directors as appropriate) should maintain regular contact with the governors to understand their issues and concerns.

2.11 Governors should seek the views of members and the public on material issues or changes being discussed by the trust. Governors should provide information and feedback to members and the public at large regarding the trust, its vision, performance and material strategic proposals made by the trust board.

2.12 It is also incumbent on the board of directors to ensure governors have the mechanisms in place to secure and report on feedback that enables them to fulfil their duty to represent the interests of members and the public at large.

2.13 The chair should ensure that the views of governors and members are communicated to the board as a whole. The chair should discuss the affairs of the NHS foundation trust with governors. Non-executive directors should be offered the opportunity to attend meetings with governors and should expect to attend them if requested to do so by governors. The senior independent director should attend sufficient meetings with governors to hear their views and develop a balanced understanding of their issues and concerns.

2.14 The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report.

2.15 The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, eg through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.

3. Additional statutory requirements

3.1 The council of governors has a statutory duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors.

3.2 The 2006 Act, as amended, gives the council of governors a statutory requirement to receive the following documents. These documents should be provided in the annual report as per the NHS foundation trust annual reporting manual:

(a) the annual accounts

(b) any report of the auditor on them

(c) the annual report.

3.3 The directors must provide governors with an agenda prior to any meeting of the board, and a copy of the approved minutes as soon as is practicable afterwards. There is no legal basis on which the minutes of private sessions of board meetings should be exempted from being shared with the governors. In practice, it may be necessary to redact some information, eg for data protection or commercial reasons. Governors should respect the confidentiality of these documents.

3.4 The council of governors may require one or more of the directors to attend a meeting to obtain information about the trust's performance of its functions or the directors' performance of their duties, and to help the council of governors decide whether to propose a vote on the trust's or directors' performance.

3.5 Governors should use their rights and voting powers from the 2012 Act to represent the interests of members and the public at large on major decisions taken by the board of directors. These voting powers require:

- More than half the members of the board of directors who vote and more than half the members of the council of governors who vote to approve a change to the constitution of the NHS foundation trust.
- More than half the governors who vote to approve a significant transaction.
- More than half the governors to approve an application by a trust for a merger, acquisition, separation or dissolution.
- More than half the governors who vote to approve any proposal to increase the proportion of the trust's income earned from non-NHS work by 5% a year or more. For example, governors will be required to vote where an NHS foundation trust plans to increase its non-NHS income from 2% to 7% or more of the trust's total income.
- Governors to determine together whether the trust's non-NHS work will significantly interfere with the trust's principal purpose, which is to provide goods and services for the health service in England, or its ability to perform its other functions.

3.6 NHS foundation trusts are permitted to decide themselves what constitutes a 'significant transaction' and may choose to set out the definition(s) in the trust's constitution. Alternatively, with the agreement of the governors, trusts may choose not to give a definition, but this would need to be stated in the constitution.

3.7 In taking decisions on significant transactions, mergers, acquisitions, separations or dissolutions, governors need to be assured that the process undertaken by the board was appropriate, and that the interests of the public at large were considered. A council may disagree with the merits of a particular decision of the board on a transaction, but still give its consent because due diligence has been followed and assurance received. To withhold its consent, the council of governors would need to provide evidence that due diligence was not undertaken.

3.8 The external auditors of a foundation trust must be appointed or removed by the council of governors at a general meeting of the council.

4. Lead governor

4.1 The lead governor has a role in facilitating direct communication between NHS England and the NHS foundation trust's council of governors. This will be in a limited number of circumstances and, in particular, where it may not be appropriate to communicate through the normal channels, which in most cases will be via the chair or the trust secretary, if one is appointed.

4.2 It is not anticipated that there will be regular direct contact between NHS England and the council of governors in the ordinary course of business. Where this is necessary, it is important that it happens quickly and in an effective manner. To this end, a lead governor should be nominated and contact details provided to NHS England, and then updated as required. Any of the governors may be the lead governor.

4.3 The main circumstances where NHS England will contact a lead governor are where we have concerns about the board leadership provided to an NHS foundation trust, and those concerns may in time lead to our use of our formal powers to remove the chair or non-executive directors. The council of governors appoints the chair and non-executive directors, and it will usually be the case that we will wish to understand the views of the governors as to the capacity and capability of these individuals to lead the trust, and to rectify successfully any issues, and also for the governors to understand our concerns.

4.4 NHS England does not, however, envisage direct communication with the governors until such time as there is a real risk that an NHS foundation trust may be in breach of its licence. Once there is a risk that this may be the case, and the likely issue is one of board leadership, we will often wish to have direct contact with the NHS foundation trust's governors, but quickly and through one established point of contact, the trust's nominated lead governor. The lead governor should take steps to understand our role, the available guidance and the basis on which we may take regulatory action. The lead governor will then be able to communicate more widely with other governors. Similarly, where individual governors wish to contact us, this would be expected to be through the lead governor.

4.5 The other circumstance where NHS England may wish to contact a lead governor is where, as the regulator, we have been made aware that the process for the appointment of the chair or other members of the board, or elections for governors or other material decisions, may not have complied with the NHS foundation trust's constitution, or alternatively,

while complying with the trust's constitution, may be inappropriate. In such circumstances, where the chair, other members of the board of directors or the trust secretary may have been involved in the process by which these appointments or other decisions were made, a lead governor may provide us with a point of contact.

Appendix C: The code and other regulatory requirements

Although compliance with the provisions in this guide is not necessarily mandatory, some of the provisions in this document are statutory requirements because they are enshrined elsewhere in legislation.

In the first instance, boards, directors and, for NHS foundation trusts, governors, should ensure that they are meeting the governance requirements for NHS foundation trusts as set out in the 2006 Act (as amended by the 2012 Act) and reflected in the NHS provider licence. This code sits alongside a number of other NHS England reporting requirements that relate to governance.

NHS England uses reasonable evidence, from disclosures made to us by NHS foundation trusts and NHS trusts, to determine if there is a risk of a breach of the licence condition 'Foundation Trust Condition 4: Governance in the NHS foundation trust' and to make a decision regarding intervention.

The information we receive includes: a **forward looking** disclosure on corporate governance (the corporate governance statement); a **backward looking** disclosure on corporate governance (the code of governance for NHS provider trusts); and a **backward looking statement on internal control, risk and quality governance** (the annual governance statement).

For clarity, here we have provided a brief explanation of how the different requirements sit together and the purpose of each.

Corporate governance statement – in the annual plan

To comply with the provider licence, the Annual Plan also includes a requirement for a corporate governance statement. This is a mandatory requirement. This is a forward looking statement of expectations regarding corporate governance arrangements over the next 12 months and trusts should be aware that **"issues not identified and subsequently arising can be used as evidence of self-certification failure"**. The requirement for the completion of the corporate governance statement is separate to the disclosure requirements of this code.

The code disclosure requirements – listed in this document and the NHS foundation trust annual reporting manual and Department of Health and Social Care Group accounting manual

This document is designed to set out **standards of best practice for corporate governance.** It is not mandatory to comply with this guidance, however, the NHS foundation trust annual reporting manual and Department of Health and Social Care group accounting manual do require trusts to make some specific disclosures on a 'comply or explain' basis regarding the provisions listed in this document. (A detailed list of the disclosures required is provided in Schedule A of this.) This is a backward looking statement which should be submitted with the annual report.

Annual governance statement – in the NHS foundation trust annual reporting manual and Department of Health and Social Care Group accounting manual

In addition to listing the code disclosure requirements, the NHS Foundation trust annual reporting manual and Department of Health and Social Care Group accounting manual also require an annual governance statement. The annual governance statement is a backward looking statement which captures information on risk management and internal control, and includes some specific requirements on quality governance.

Completion of the Annual governance statement is a **mandatory requirement.** The annual governance statement does not relate to this code.

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Addendum to Your statutory duties – reference guide for NHS foundation trust governors

System working and collaboration: role of foundation trust councils of governors

27 October 2022

Contents

Equality and health inequalities statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

About this document

This addendum supplements existing guidance for NHS foundation trust governors and explains how the legal duties of foundation trust councils of governors support system working and collaboration.

Key points

- This addendum is based on the existing statutory duties in the 2006 Act, and the principles regarding collaboration and system working in the June 2021 Integrated care systems: design framework.
- To support collaboration between organisations and the delivery of better, joined-up care, councils of governors are required to form a rounded view of the interests of the 'public at large'.
- Updated considerations are set out in respect to the following legal duties of councils of governors: holding the non-executive directors to account, representing the interests of trust members and the public, and approving significant transactions, mergers, acquisitions, separations or dissolutions.
- This addendum only applies to a council of governors' statutory role within its own foundation trust's governance.

Action required

- NHS England expects councils of governors to act in line with the principles in this addendum.

Other guidance and resources

- Integrated care systems: design framework
- Working together at scale: guidance on provider collaboratives
- The wider suite of Integrated care systems: guidance

1. Introduction

This addendum to NHS England's Your statutory duties: A reference guide for NHS foundation trust governors (the guide for governors), originally published by Monitor, explains how the duties of NHS foundation trust councils of governors support system working and collaboration, and provides examples of good practice. It supplements (rather than replaces) the guide for governors, and the two documents should be used in conjunction.

The guide for governors lays out the statutory duties of NHS foundation trust councils of governors, as provided by the National Health Service Act 2006 (the 2006 Act) and amended by the Health and Social Care Act 2012. It is written for councils of governors (rather than trust boards). The legislation applies to councils of governors as a whole, not individual governors. Councils have no powers of delegation, so they can only take decisions in full council.

There is no change to the statutory duties for councils of governors, as outlined in the 2006 Act. For more details on any of the NHS foundation trust councils of governors' statutory duties and powers, please refer to the legislation or contact your trust secretary.

This addendum is based on the statutory duties in the 2006 Act and the principles regarding collaboration and system working in the June 2021 Integrated care systems: design framework and the Health and Care Act 2022. NHS England expects councils of governors to act in line with the principles in this addendum.

This addendum only applies to a council of governors' role **within its own foundation trust's governance**. It does not relate to the governance of the boards of integrated care boards (ICBs).

1.1 What has changed and why?

Background

A great deal has changed since the guide for governors was last updated in August 2013. With the publication of the NHS Long Term Plan (a 10-year plan outlining the

future of the NHS) in January 2019, the NHS set out its ambition to develop new ways of working based on the principles of co-design and collaboration.[1]

These principles are not new to the NHS, as 'working together for patients' has been a core part of the NHS Constitution since 2012. However, the importance of different parts of the health and care system working together in the best interests of patients and the public has been starkly demonstrated during the COVID-19 pandemic. The immediate and long-term challenges facing the NHS, such as an ageing population, increased demand for services and health inequalities, can only be solved by organisations working together and putting patients, service users and populations at the heart of decision-making.

A key milestone in achieving this was the establishment of integrated care systems (ICSs) across England. ICSs bring local health and care organisations together to deliver the priorities for the health and care system, including complying with the triple aim of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources.[2] They do this over the defined geographical area, and depend on NHS organisations, local authorities and other partners that deliver health and care services working together to plan care that meets the needs of their population. This approach is often called 'system working'.

The Health and Care Act 2022 has removed legal barriers to collaboration and integrated care and put ICSs on a statutory footing by establishing for each ICS:

- An integrated care partnership (ICP), a statutory joint committee of the ICB and the responsible local authorities in the ICS, bringing together organisations and representatives concerned with improving the care, health and wellbeing of the population. Each partnership has been established by the NHS and local government as equal partners and has a duty to develop an integrated care strategy proposing how the NHS and local government should exercise their functions to integrate health and care and address the needs of the population identified in the local joint strategic needs assessment(s).
- An ICB, which brings the NHS together locally, to improve population health and care; its unitary board allocates NHS budget and commissions services, and – having regard to the ICP's integrated care strategy – produces a five-year joint

[1] NHS Long Term Plan, p110, 7.1.
[2] Integration and innovation: working together to improve health and social care for all p23, 3.11.

plan for health services and annual capital plan agreed with its partner NHS trusts and foundation trusts.

The ICP and ICB, together with other key elements of the new arrangements including place-based partnerships and provider collaboratives, will bring together all partners within an ICS.

As ICSs develop, organisations are not only expected to provide high-quality care and manage their own finances, but to take on responsibility for wider objectives relating to NHS resources and population health jointly with other providers. This means that system and place-based partnerships will plan and co-ordinate services in a way that improves population health and reduces inequalities.

The success of individual trusts and foundation trusts will increasingly be judged against their contribution to the objectives of the ICS, in addition to their existing duties to deliver safe, effective care and effective use of resources.[3] Trusts are also expected to avoid making decisions that might benefit their own institution but worsen the position for the system overall.[4]

Forming a rounded view in representing 'the public'

The 2006 Act provides councils of governors with their statutory duties. Within those duties, councils of governors are legally responsible for representing the interests of the members of the NHS foundation trust and the public.[5]

While the meaning of 'the public' is not specified in legislation, councils of governors are not restricted to representing the interests of a narrow section of the public served by the NHS foundation trust – that is, patients and the public within the vicinity of the trust or those who form governors' own electorates.

To support collaboration between organisations and the delivery of better, joined-up care, councils of governors are required to form a rounded view of the interests of the 'public at large'. This includes the population of the local system of which the NHS foundation trust is part. No organisation can operate in isolation, and each is dependent on the efforts of others.

[3] Integrated care systems: design framework, p30.
[4] NHS Long Term Plan, p112, 7.9.
[5] Paragraph 10A(b) of Schedule 7 to the NHS Act 2006.

While staff governors and patient, carer and service user governors represent specific constituencies, they are also expected to represent the interests of the members of the trust as a whole and the public. Therefore, they are required to seek and form a view of the interests of the 'public at large'.

This expectation also extends to appointed governors.[6] The continued expectation of appointed governors is that they will work to further the relationship between their own organisation and the NHS foundation trust, but do so within the context of the system, of which they are part.

There is no requirement for trusts to appoint a governor from an ICB; however, they are free to do so, if they wish.

2. Updated considerations for the statutory duties of councils of governors

The statutory duties of councils of governors have not changed, and governors should not anticipate any material change to their day-to-day role.

However, the NHS' move to a new way of working will affect what councils of governors need to consider when performing their statutory duties. Councils of governors will need to be assured their foundation trust board has considered the consequences of decisions on other partners within their system, and the impact on the public at large.

This section provides clarity on the three statutory duties that will be most affected by the transition to system working, setting out additional considerations for each duty, that reflect the new context trusts are operating in:

a. Holding the non-executive directors individually and collectively to account for the performance of the board of directors.
b. Representing the interests of the members of the NHS foundation trust and the public.

[6] At least one governor is required to be appointed by a qualifying local authority and at least one by a university if the hospitals include a medical or dental school provided by a university. A foundation trust can decide whether to have any further appointing organisations, specifying as such in its constitution.

c. Approving ‘significant transactions’, mergers, acquisitions, separations or dissolutions.[7]

Chapter 3 of the guide for governors gives the complete statutory duties and powers of the council of governors.

2.1 General duties of the council of governors (Chapter 4 of the guide for governors)

a. Holding the non-executive directors to account

What are the legal requirements?

The council of governors has a duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors.

General considerations

The guide for governors stipulates: “Holding the non-executive directors to account for the performance of the board does not mean the governors should question every decision or every plan. The role of governors in ‘holding to account’ is one of assurance of the performance of the board.”[8] It suggests that the council of governors should therefore assess what it believes are the key areas of enquiry and provide appropriate challenge. These could be for example:

- due process is not being followed
- the interests of the members and of the public are not being appropriately represented
- the trust is at risk of breaching the conditions of its licence.

Councils of governors may not always agree with the decisions taken by the directors, and directors do not always have to adhere to the council’s preferences. However, the board of directors, as a whole, does have to give due consideration to the views of the council of governors, especially in relation to matters that concern the interests of the members of the NHS foundation trust and the public.[9]

[7] Your statutory duties – a reference guide for governors, p19.
[8] Your statutory duties – a reference guide for governors, p28.
[9] Ibid.

Chapter 4, section 4.1 of the guide for governors gives a complete description of this duty.

What is the role of councils of governors?

Overall responsibility for running an NHS foundation trust lies with the board of directors, and the council of governors is the collective body through which directors explain and justify their actions. Holding to account is therefore not about the performance of individual directors, nor performance management of the board – that is, the council's role is as follows:

1. To consider the board's account of its performance against the criteria that the council has agreed with the board and based on the conditions in the provider licence.
2. To question the board on its account and feedback in a considered manner based on the evidence presented (asking for more evidence if necessary and reasonable).
3. In extreme cases, to raise difficult issues and, after listening to the account of the board, to consider contacting NHS England if it forms a reasonable belief that the trust is in danger of breaching the terms of its licence.

Updated considerations for governors to discuss with their trust's board regarding system working

1. The success of an individual foundation trust will increasingly be judged against its contribution to the objectives of the ICS. This means the board's performance must now be seen in part as the trust's contribution to system-wide plans and their delivery, and its openness to collaboration with other partners, including with other providers through provider collaboratives. In holding non-executive directors to account for the performance of the board, NHS foundation trust councils of governors should consider whether the interests of the public at large have been factored into board decision-making, and be assured of the board's performance in the context of the system as a whole, and as part of the wider provision of health and social care.

   Councils of governors are permitted to demonstrate the interests of the public at large to the board if they feel that the board is not operating in the public's

interests. (For further detail, please see Section 2.1b: Representing the interests of trust members and the public.)

2. Consideration should also be given to how the trust board's decision-making complies with the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources, as well as the role the trust is playing in reducing health inequalities in access, experience and outcomes.

3. The statutory duties of councils of governors have not changed, and the relationship of councils of governors remains with their own foundation trust board, the ICB or any other part of the system(s) their trust operates in. It remains the case that if governors are acting outside the context of a council meeting they do so solely as individuals, ie outside their statutory role as governor.

Illustrative scenario 1: A council of governors considers the role the NHS foundation trust has played within the ICS in holding the non-executive directors to account for the performance of the board

To hold the non-executive directors to account, the council of governors may already have a number of approaches in place, including:

1. Observing the contributions of the non-executive directors at board meetings and during meetings with governors.
2. Gathering information on the performance of the board against its strategy and plans.
3. Receiving the trust's quality report and accounts and questioning the non-executive directors on their content.

These allow the council of governors to determine its key areas of concern and provide appropriate challenge.

The council of governors is mindful that NHS England has now set a clear expectation that NHS foundation trusts will collaborate effectively with system partners to co-design and deliver plans, and that the failure of a trust to do so may be treated as a breach of governance licence conditions.

To form a view about the trust's contribution to system performance and development, the council of governors may need to adapt its approaches.

1. Seeking to understand the arrangements for the trust's contribution to shared planning and decision-making forums – eg system and place-based arrangements and provider collaboratives – and how the interests of patients and the public are considered.

2. Requesting information on the ICP's integrated care strategy and the ICB's five-year joint plan from the board to understand how the trust's plans relate to overarching system development.

3. Requesting information on the ICB's performance from the board to understand how the trust's performance relates to that of its system.

4. Receiving assurance from non-executive directors that the board's decisions comply with the triple aim duty – better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources – and have the opportunity to question the non-executive directors about this.

The trust is expected to ensure that the council of governors is provided with appropriate information, and that the governors are given opportunities to meet the board to raise questions about the trust's role within the system, or systems, of which it is part.

b. Representing the interests of trust members and the public

What are the legal requirements?

Under the 2006 Act, councils of governors have a duty to represent the interests of the members of the NHS foundation trust and the public.

General considerations

The general duty to represent the interests of members and the public includes (but is not limited to) all other statutory duties that councils of governors are expected to fulfil, and should underpin all elements of their role as outlined in the guide for governors and the NHS foundation trust's own constitution. The council of governors should therefore interact regularly with the members of the trust and the public to ensure it understands their views, and to clearly communicate information on trust and system performance and planning in return. However, governors should take care to disclose only those matters that the trust considers non-confidential.[10]

Councils of governors must be mindful that a number of different bodies and organisations (such as Healthwatch) represent the interests of the public, and governors should therefore work collaboratively with one another and with other representative bodies, to ensure that the public has been as broadly represented as possible.

It should be noted that while staff, patient, carer and service user governors represent specific constituencies, they are also expected to represent the interests of the members of the trust as a whole and the public at large.

Chapter 4, section 4.2 of the guide for governors gives a complete description of this duty.

Updated considerations for governors to discuss with their trust's board regarding system working

1. Each ICB will be expected to build a range of engagement approaches into its activities at every level, and to prioritise engaging with groups affected by health inequalities in access, experience and outcomes, in a culturally competent way. This will be supported by a legal duty for each ICB to make arrangements to involve patients, unpaid carers and the public in planning and commissioning arrangements, and by a continuation of existing foundation trust duties relating to patient and public involvement, including the role of foundation trust governors.
2. Councils of governors are not restricted to representing the interests of a narrow section of the public served by the NHS foundation trust – that is, patients and the

[10] Your statutory duties – a reference guide for governors, p31.

public within the vicinity of the trust or those who form governors' own electorates. To discharge this statutory duty, councils of governors are required to take account of the interests of the 'public at large'. This includes the population of the local system of which the trust is part.

3. **There is no expectation that the way governors undertake this duty should materially change.** However, councils of governors should be assured that their trust is engaging widely, and when engaging with the public themselves, councils of governors need not limit their engagement to the public and patients in their electorate or personal networks. They may also work with their board to consider how best to engage with other bodies and organisations in their system that represent the interests of the public at large (such as voluntary sector organisations and Healthwatch). Governors must also adhere to their trust's communications or media policies when engaging and communicating with the public.

4. In some cases, councils of governors will need to consider the interests of patients and the public in other parts of their system and beyond their own ICS. This can be because the trust:

    a. is located within a large ICS or is geographically distant from other system partners

    b. has a specialist service footprint

    c. is near a geographical boundary and may provide services to members and patients from other ICSs

    Governors should work with their board to consider how to represent the interests of the public across a wide geographical footprint or in other ICSs.

Illustrative scenario 2: An NHS foundation trust and its council of governors work together to strengthen mechanisms by which the council of governors can consider the views of the wider public

The council of governors may already have various ways through which it engages with members and the public. These may include governor drop-in events where members and the public can meet governors, a dedicated page on the foundation trust's website to share information and surveys to gather members' and the public's views. The council of governors may also have agreed routes for feeding views back to the board, such as regular reports or presentations at council meetings.

To strengthen mechanisms to consider the views of the wider public, the council of governors should take additional steps:

1. Working with the trust to use technology to engage with members and the public. This could include adding to face-to-face interactions with virtual engagement via online events, which could improve accessibility for some patient cohorts and the public.

2. Considering how it can engage with other stakeholders that have a role in promoting the interests of patients and the public, eg local branches of Healthwatch and voluntary sector organisations. Governors may also work with their trust to build relationships with organisations that can help gather the views of seldom heard groups.

3. Asking for information on how the trust intends to address health inequalities in both its own plan and contributing to that for the wider system. This could be supplemented as appropriate with the population health data (eg demographics and deprivation data) that underpins the ICB's planning, including the identification of unmet need. This helps the council of governors understand the impact of action taken by the trust to address health inequalities.

4. If the trust's footprint is wide, or even extends beyond its ICS (because it sits in a large ICS, provides specialist services or sits on a geographical boundary), the council of governors might work with its board to consider how best to represent the interests of members and the public; for example, by:

a. being aware of how the trust's services are used and accessed

b. being assured that the trust has considered the impact of any changes or decisions on the public using its services, irrespective of what system they are in

c. being assured that the trust has assessed the impact of its decisions on the care being provided to patients across the ICS.

2.2 Taking decisions on significant transactions, mergers, acquisitions, separations and dissolutions (Chapter 10 of the guide for governors)

c. Approving significant transactions, mergers, acquisitions, separations or dissolutions

Chapter 10 of the guide for governors explains what a 'significant transaction' is.

It may also be helpful to refer to Appendix 10: Legal and regulatory requirements for transactions of the Transactions guidance[11] for a more detailed and operational definition.

What are the legal requirements?

Under the 2012 Act:

- **More than half the members of the full council of governors of the trust voting** need to approve the foundation trust entering into any significant transaction, as specified in the trust's constitution. This means more than half the governors who are in attendance at the meeting and who vote at that meeting.
- **More than half the members of the full council of governors** must approve any application by the foundation trust to merge with or acquire another trust, to separate the trust into two or more new NHS foundation trusts or to dissolve the trust. This means more than half the total number of governors, not just half the number who attend the meeting at which the decision is taken. If the other party

[11] Assuring and supporting complex change: Statutory transactions, including mergers and acquisitions

to the proposed transaction is also an NHS foundation trust, more than half the governors of that foundation trust must also approve the transaction.[12]

What are councils of governors asked to take a decision on?

The 2006 Act states that the foundation trust's constitution "must provide for all the powers of the organisation to be exercisable by the board of directors on its behalf".[13] As such it is the board of directors that must decide whether a transaction should proceed.

Councils of governors are responsible for assuring themselves that the board of directors has been thorough and comprehensive in reaching its decision to undertake a transaction (that is, has undertaken due diligence), and that it has appropriately considered the interests of members and the public as part of the decision-making process.[14] As long as they are appropriately assured of this, governors should not unreasonably withhold their consent for a proposal to go ahead.[15] They should consider the implications of withholding consent in terms of the key risks the transaction was designed to address.

Given councils of governors have no power of delegation, they can only make decisions in full council. Hence, they should attempt to reach a consensus based on the broad views of the council members. In common with boards of directors, they should not allow themselves to be unduly influenced by the views of individuals, but instead should attempt to ensure that all voices are heard and considered.

The council of governors must obtain sufficient information from the board of directors on the proposed significant transaction, merger, acquisition, separation or dissolution to make an informed decision.[16]

Chapter 10 of the guide for governors gives a more complete description of this duty.

[12] Your statutory duties – a reference guide for governors, p60.
[13] Paragraph 15(2) of Schedule 7 to the NHS Act 2006.
[14] Your statutory duties – a reference guide for governors, p63–4.
[15] Ibid.
[16] Ibid.

Updated considerations for governors to discuss with their trust's board regarding system working

1. Governors need to be assured that the process undertaken by the board in reaching its decision was appropriate, and that the interests of the 'public at large' were considered. A council can disagree with the merits of a particular decision of the board on a transaction, but still give its consent because due diligence has been followed and assurance received. To withhold its consent, the council of governors would need to establish that appropriate due diligence was either not undertaken or properly factored into decision-making.

2. All transaction proposals need to demonstrate a clear case for change to meet NHS England's assurance requirements, including how they will result in material improvements to the quality of services. Benefits arising from the transaction could be for the patients served by the trust or the wider public, eg by impacting patients of other providers or reducing health inequalities across the population. In the context of the NHS' new way of working, this means that councils of governors may well be expected to consent to decisions that benefit the broader public interest while not being of immediate advantage to or creating some level of risk for their NHS foundation trust. Consent should not be given for decisions that benefit the NHS foundation trust without regard to the effect on other NHS organisations, or the overall position of a wider footprint such as an ICS.

Illustrative scenario 3: A council of governors approves a significant transaction that may not immediately benefit the individual trust but overall does benefit the population of the wider ICS

The council of governors provides consent because the board has adequately assured it that the appropriate process has been followed.

This significant transaction may not immediately benefit the individual NHS foundation trust but overall is expected to benefit the population of the wider ICS. Some governors disagreed with the merits of the board's proposed transaction, but the full

council gave consent because all processes have been followed, the interests of the public at large have been considered and assurance has been received.

To reach this decision:

1. The board provided the council of governors with appropriate information on the proposed transaction, including the benefits for patients and the public in the wider ICS, and the impact on quality of services, system performance and the system's financial position.
2. The board was open about any risks and opportunities for the NHS foundation trust and how these would be addressed.
3. The board provided evidence that the interests of the public were appropriately considered, and effective engagement processes were followed. The council of governors was given the opportunity to challenge the processes and to ask the non-executive directors questions around any key areas of concern.

3. Working with the board

This section contains suggested approaches to support better working between the council of governors and the board, along with examples of developmental activities already underway across trusts.

3.1 Building relationships and understanding roles

Key relationships

- Trust secretary/membership manager and governor liaison role
- Trust chair
- Trust non-executive directors
- Trust chief executive officer
- Trust board and/executive directors
- Foundation trust members

Practical tips

Governors will receive an induction from their organisation. They should familiarise themselves with the following documents, along with any others their trust secretary, membership manager or anyone in a governor liaison role signposts them to:

- trust's constitution
- Code of Conduct
- confidentiality and data protection policies
- conflict of interest policies
- communications policy
- Nolan principles.

These documents help governors understand the principles and processes by which their trust is governed, outline the composition and general duties of the board, and set out expectations of governor conduct.

It is important that trust boards and their governors act in line with the Nolan principles and are open and transparent with one another. Doing so creates a better environment for challenging conversations.

For more information please refer to Chapter 2 of Your statutory duties: A reference guide for NHS foundation trust governors which outlines the governance structure of NHS foundation trusts. Please also see your trust's own constitution for information that is specific to your own organisation.

3.2 Supporting governors to fulfil the duties of a council of governors

Key relationships

- Trust secretaries/membership manager and governor liaison role
- Trust chair
- Trust non-executive directors
- Trust chief executive officer
- Trust board/executive directors

Expectations: communications and engagement

Governors can expect to attend a variety of meetings organised by the trust, which intend to help inform their decision-making, and to support governors in fulfilling their duties. Formally, this will include council of governor meetings and annual members meetings. Governors should also be encouraged to attend public trust board meetings. The trust may also organise other meetings or forms of engagement such as:

- informal meetings such as Q&As with the chief executive or chair, and workshops with the non-executive directors or board
- regular briefings to members and governors from the chief executive or chair
- ad-hoc briefings or dissemination of information as an issue arises
- non-executive director updates at council of governor meetings.

The board should engage early with the governors about transaction plans. From the outset directors and governors should agree a process for engagement on the transaction, to include:

- the content and timing of information to be provided to governors and any training needs
- how the views of members will be sought and stakeholders kept informed
- how governors can get involved with developing the future governance model, eg by working on the constitution for the post-transaction foundation trust.[17]

3.3 Supporting governors to understand their duties in the context of ICSs and system working

Key relationships

- Trust chair
- Trust chief executive officer
- Trust board secretary/membership manager and governor liaison role

Expectations: communications and engagement

- The trust's chair should facilitate engagement between the ICB, the ICP and the trust's council of governors.

[17] Assuring and supporting complex change: Statutory transactions, including mergers and acquisitions

- The trust should also ensure governors are updated in a timely way on system plans, decisions and delivery.
- The trust should ensure governors receive information on the ICP's integrated care strategy and the ICB' five-year forward plan, as decisions and aspects of delivery that directly affect the trust and its patients.
- The council of governors should consider how it can support its board to engage with patients and the community across the geography of the ICS.

There is no agreed way that a trust should do this. Suggestions based on existing examples are:

- Attending public trust board meetings to listen to the discussion on ICS arrangements. This should also indicate whether the board is acting in the wider public interest and provides an opportunity to hear the types of questions non-executive directors are asking in this respect.
- Board members providing ICS updates at council meetings to ensure that governors are well informed and have an opportunity to ask questions.
- Governor engagement sessions arranged by the ICB or ICP to update on progress in the delivery of system plans.
- The chair cascading key messages after an ICP or ICB meeting.

Practical tips

Your trust should work with governors to understand the following:

- What is the foundation trust's ICS footprint?
- Who are the key partners in the system?
- What is the membership of the ICP?
- What is the membership of the board and committees of the ICB?
- How is the trust contributing to the ICS, and what is the impact of the ICS on existing trust plans?
- How is the trust's decision-making complying with the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources?
- How can the council of governors support the trust in leading in or contributing to its ICS?

- How can the council of governors best communicate the ICS plans to the trust members and public?

4. Further information

For national context:

- NHS Long Term Plan
- Integration and innovation: working together to improve health and social care for all
- Integrated care systems: design framework

Relevant NHS England guidance:

- Statutory transactions guidance
- Guidance on pay for very senior managers in NHS trusts and foundation trusts
- NHS Oversight Framework 2022/23
- Guidance on good governance and collaboration

Other resources for governors:

- Govern Well – NHS providers' national training programme for governors

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Report to:	Council of governors
Agenda item:	7-23
Date of meeting:	17 April 2023
Report from:	Antony Fulford-Smith, public governor and committee Chair
Report author:	Antony Fulford-Smith, public governor and committee Chair
Date of report:	11 April 2023
Appendices:	None

Update from governor working group on public engagement

The Working group has met three times since the Council of Governors (CoG) meeting in January.

We circulated a newsletter as agreed with CoG to the trust membership who had provided an email address (3386 out of 7500members) as well as local parish councils, patient groups and GP practices.

2123 members opened the trust email announcing our interim CEO and 167 clicked through to the governor newsletter (5%). We received two member emails – one highly supportive and one related to a specific patient's treatment which was redirected.

East Grinstead town council, Lingfield, West Hoathly, Speldhurst and Ashurstwood invited us to attend meetings (all open public meetings – 3 annual meetings for parish).

The issues raised have included:

- At every meeting 2-3 people have spoken of the fantastic specialist care received at QVH
- Our local public wish to see services expanded at QVH is possible – specialist and local
- Cross county border referrals and access to therapies seems to be an issue for Surrey residents (example given was physio)
- Access to general practice is an issue for patients in EG (as also previously reported from Age Concern meeting)
- When pushed on issues at QVH - Parking is raised, both lack of and ability to see the meter screens if glare or rain
- General information about QVH such as in Lingfield newsletter would be welcomed
- There appeared low awareness of commissioning structures at any of the meetings

We also received invitations to and have attended meetings with patient groups, including Restore, Headstart and the Burns Support Group. To summarise, these were very enlightening; shining a light on the terrific value patients derive from these groups and the significant work that both volunteers and several of the trusts staff provide. They are a vital part of the 'care mix'.

Patient groups are concerned about waiting times and access to services (breast reconstructive surgical services) but hugely appreciative and supportive of the work of QVH in all our major specialist areas.

The working group have proposed that we try to make newsletters more regular and ask questions to raise engagement further.

The majority of members on the working group are not eligible or not standing for re-election so a new Chair and working group membership is proposed to be put in place once new governors are elected.

Recommendation
Council is asked to **note** the update.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/01/2023		**Agenda reference:**	**209-23**	
Report title:	Financial, operational and workforce performance assurance				
Sponsor:	Paul Dillon-Robinson, Non-executive director, Chair of Finance & Performance Committee				
Author:	Paul Dillon-Robinson, Non-executive director, Chair of Finance & Performance Committee)				
Appendices:	None				
Executive summary					
Purpose of report:	Assurance on financial, operational and workforce performance as discussed at the latest Finance & Performance Committee (28 November 2022)				
Summary of key issues	• Increased referrals, late referrals and patient choice are all impacting performance areas such as 2WW and 62+ for cancer • Assurance received that the 78WW will be eliminated by year end • Break even financial position forecasted for year end due to the current funding settlement which is unlikely to continue into the next financial year				
Recommendation:	The Board is asked to **note** the contents of the report.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO1: *Outstanding patient experience*	KSO2: *World-class clinical services*	KSO3: ***Operational excellence***	KSO4: ***Financial sustainability***	KSO5: ***Organisational excellence***
Implications					
Board assurance framework:	BAFs for KSO3, KSO4 and KS05 are relevant and were reviewed at the meeting				
Corporate risk register:	Corporate risks allocated for oversight by the committee were reported upon and note is made where individual risks received more detailed review – if applicable				
Regulation:	Some KPIs link into the oversight framework of reporting to NHSE and CQC				
Legal:	None				
Resources:	Resources are fundamental to the delivery of performance				
Assurance route					
Previously considered by:	Finance, operational and workforce reports go through a variety of routes to reach the committee				
	Date:		Decision:		
Next steps:					

Report to:	Board Directors
Agenda item:	Financial, operational and workforce performance assurance
Date of meeting:	12 January 2023
Report from:	Paul Dillon-Robinson, Non-executive director, Chair of Finance & Performance Committee
Report author:	Paul Dillon-Robinson, Non-executive director, Chair of Finance & Performance Committee
Date of report:	20 December 2022
Appendices:	None

Financial, operational and workforce performance assurance

Introduction
The Finance & Performance Committee meets monthly to review regular reports on financial, operational and workforce matters, as well as topics set out in an annual workplan.

This report covers the meeting of the Finance & Performance Committee on 28 November, reviewing performance information as at the end of October 2022. The next meeting, reviewing November performance, is scheduled for Wednesday 11 January and a verbal update will be provided at the Board meeting of any significant issues.

Operational Performance
The committee continues to maintain a focus on cancer treatment waiting times. The increased level of referrals (seen in this and some other areas), combined with patient choice and some late referrals has had an impact on performance, in such areas as 2ww and 62+ days for cancer.

Trajectories for what the Trust's year-end 52ww figure will be, have fluctuated in recent months, with particular pressures within plastics, although assurance is being given that the 78ww will be eliminated by year-end. Further work on this area is being undertaken.

The performance of sleep services remains a concern, with the remedial actions taking longer to implement than planned.

Productivity within theatres was also focused on, both in terms of the impact of the maintenance work as well as the ongoing volume of on the day cancellations. Further work on pre-assessment was to be considered.

Workforce performance
Whilst the current vacancy rate is within the KPI target, there remain challenges in hard to recruit areas.

The committee discussed a proposal to change the sickness absence target (3%), with the average in the region being 3.8%, but required further analysis.

There was further discussion on how assurance could be gained on the effectiveness of appraisals and some sampling is now being undertaken. The committee was assured that any appraisals more than three months overdue are escalated.

Financial performance
The Trust continues to report a break-even position, both year-to-date and in the year-end forecast. Pay and non-pay remain broadly in line with trend.
The committee also received a report on the system's financial position, and the financial challenges being faced by our system partners and, hence, the importance that the Trust plays its part.

The Trust continues to report a financial break-even position for this year, due to the current funding settlement, which is very unlikely to continue into 2023/24. Whilst there remain vacancies in a number of areas, workforce utilisation is static. There is also increased demand, in some areas, for services, but still a need to focus on productivity.

Other
The committee received an update on 2023/24 business planning; noting the focus on determining the activity, capacity, cost, and workforce baseline for a post-Covid hospital. It noted the changing demand for some services and the need for engagement with commissioners on the activity assumptions, for which assurance was given.

Corporate risks on junior doctor rota management in plastics, and the unregulated use of data sharing apps were subject to deep dive reviews. Updates on the Digital Programme and the Green Plan were also subject to review.

Recommendation
The Board is asked to **NOTE** the matters raised above and discuss any issues that they feel appropriate

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	2/3/2023		**Agenda reference:**	**238-23**	
Report title:	Financial, operational and workforce performance assurance				
Sponsor:	Paul Dillon-Robinson, Non-executive director, Chair of Finance & Performance Committee				
Author:	Paul Dillon-Robinson, Non-executive director, Chair of Finance & Performance Committee)				
Appendices:	N/A				
Executive summary					
Purpose of report:	Assurance on financial, operational and workforce performance as discussed at the latest Finance & Performance Committee (23 January 2023)				
Summary of key issues	Operational performance; continuing focus on sleep services and expectations on delivering to RTT targets Workforce; positive on overall vacancy, but mindful of sickness Finance; forecasting year-end break-even, under current regime Business planning; challenges being recognised for 2023/24				
Recommendation:	The board is asked to note the matters discussed and seek further clarification.				
Action required *[embolden **one** only]*	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs): *[[embolden KSO(s) this recommendation aims to support]*	KSO1: *Outstanding patient experience*	KSO2: *World-class clinical services*	KSO3: ***Operational excellence***	KSO4: ***Financial sustainability***	KSO5: ***Organisational excellence***
Implications					
Board assurance framework:	BAFs for KSO3, KSO4 and KS05 are relevant and were reviewed at the meeting				
Corporate risk register:	Corporate risks allocated for oversight by the committee were reported upon and note is made where individual risks received more detailed review – if applicable				
Regulation:	Some KPIs link into the oversight framework of reporting to NHSE and CQC				
Legal:	No specific legal implications				
Resources:	Resources are fundamental to the delivery of performance				
Assurance route					
Previously considered by:	Finance, operational and workforce reports go through a variety of routes to reach the committee				
	Date:		Decision:		
Next steps:	Review by Board				

Report to:	Board Directors
Agenda item:	Financial, operational and workforce performance assurance
Date of meeting:	2 March 2023
Report from:	Paul Dillon-Robinson, Non-executive director, Chair of Finance & Performance Committee
Report author:	Paul Dillon-Robinson, Non-executive director, Chair of Finance & Performance Committee
Date of report:	17 February 2023
Appendices:	N/A

Financial, operational and workforce performance assurance

Introduction
The Finance and Performance Committee meets monthly to review regular reports on financial, operational and workforce matters, as well as specific topics set out in an annual workplan.

This report covers the meeting of the Finance and Performance Committee on 23 January, reviewing performance information as at the end of December 2022. The next meeting, reviewing January performance, is scheduled for Monday 27 February and a verbal update will be provided at the meeting of any significant issues.

Operational Performance
There were continued discussions around sleep services and awaiting the latest external review on demand and capacity planning for this area. Assurance was sought on the steps being taken forward for this service, given staffing issues combined with increased referrals, and that this has been a long-running issue.

The expectation remains that we will meet year-end targets for nil 78ww patients, with 52ww ahead of a revised trajectory, although the risk remains around patient choice and their being complex pathways often involving other organisations.

The work on theatre utilisation by Four Eyes was subject to detailed discussion including the importance of this, and associated, work in addressing productivity challenges. The committee still wishes to understand the reasons for “on the day” cancellations which might have been avoided (i.e. “operation not needed”, as opposed to “patient unwell” on the day).

Pressure on melanoma sentinel lymph node biopsy capacity, and the target for Patient Initiated Follow Up (“PIFU”), were also covered.

Workforce performance
It was noted that the overall vacancy rate continues to be below the target level, although individual areas have their particular challenges.

The committee sought assurance on a couple of areas where performance indicators were below target; annual appraisals that are still to be undertaken and sickness absence. Processes for appraisals are being reviewed, to try to make them easier to complete, and this area will be revisited by the committee in March. Increase in sickness absence is consistent with trends across the NHS and further work is needed to understand some of the causes (recorded as “other”), although it was acknowledged that the Trust has many initiatives in place to support staff.

Financial performance
The Trust continues to report a break-even year to date and to forecast break-even for the year-end. As with previous reports, this comes with the proviso that this is under the current funding regime and the Trust's medium/long term financial sustainability remains a major risk.

Significant slippage in capital spend was recognised and plans are being put in place to bring forward what expenditure can be brought forward, but recognising that processes need to be followed to ensure value for money.

There was also discussion on efficiency, both in year and moving forward.

Business planning
Time was spent on an update on business planning, noting the latest national guidance and requirements (elective care, follow ups, theatre utilisation, etc.), as well as the expected contracts from commissioner (aligned payment and incentive or low volume activity) and the risks to delivering that activity and receiving the income. It was noted that it was important to understand the trends in activity, in terms of volume in some areas and mix in others.

Further discussion was held, following the previous meeting, on the results of service level reporting, and how this could be used.

Other
Deep dives were undertaken on two risks; 1231 Late tertiary cancer referrals, and 1254 Speech and Language Therapists Staffing, as well as updates in Freedom of Information, Information Governance, Data Quality and Cyber Security.

Recommendation
The Board is asked to **NOTE** the matters raised above and discuss any issues that they feel appropriate

Report cover-page					
References					
Meeting title:	Board of directors				
Meeting date:	02/03/2032		**Agenda reference:**	**239-23**	
Report title:	Digital committee assurance				
Sponsor:	Kevin Gould, Committee Chair				
Author:	Leonora May, Deputy company secretary				
Appendices:	None				
Executive summary					
Purpose of report:	The purpose of the report is to provide assurance on matters considered and discussed by the digital committee at its meeting on 13 February 2023.				
Summary of key issues	• IT infrastructure spend at year end- majority of hardware delivered in time • EPR full business case to be presented to the Board for approval in July 2023 • Stakeholder engagement for the development of the digital strategy is ongoing • The pathology LIMS is being purchased by the Sussex pathology network and will replace the LIMS currently operating at QVH				
Recommendation:	The Board is asked to **note** the contents of the report.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:** ***Outstanding patient experience***	**KSO2:** ***World-class clinical services***	**KSO3:** ***Operational excellence***	**KSO4:** ***Financial sustainability***	**KSO5:** ***Organisational excellence***
Implications					
Board assurance framework:	Corporate risks related to digital				
Corporate risk register:	Digital corporate risks to be reviewed by the committee going forwards				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Digital committee				
	Date:	13/2/2023	Decision:		
Next steps:	N/A				

Report to:	Board Directors
Agenda item:	239-23
Date of meeting:	2 March 2023
Report from:	Kevin Gould, committee Chair
Report author:	Leonora May, deputy company secretary
Date of report:	22 February 223
Appendices:	None

Digital committee assurance

Introduction

This purpose of this report is to provide the Board with assurance on matters considered by the digital committee at its meeting on 13 February 2023.

Digital programmes

The committee received updates on the IT infrastructure and electronic patient record (EPR) programmes.

The committee received assurance that the majority of the hardware related to the IT infrastructure programme had been delivered on time and that mitigations remain in place for the corporate risk regarding IT infrastructure spend a year end. Unallocated capital for 2022/23 is being used to fund phase 2a of the programme.

The EPR full business case will be presented to the Board for approval at its meeting in July 2023.

Digital strategy

The committee received assurance regarding progress made against the development of a digital strategy and alignment with the development of the Trust's overarching strategy. Stakeholder engagement with this work is ongoing.

Sussex pathology laboratory information management system (LIMS)

The pathology LIMS is being purchased by the Sussex pathology network which is a collaborative partnership of University Hospitals Sussex, East Sussex Healthcare NHS Trust and QVH and will replace the LIMS currently operating at QVH.

The committee noted that QVH will access the new module via the University Hospitals Sussex system and that and that there will be no cost implication for the first year. The committee requested confirmation regarding the costs for the second year onwards.

Development of digital committee portfolio

There are some items that will be moved from the finance and performance committee work programme to the digital committee's work programme which is being developed for review at its next meeting.

The digital committee and finance and performance committee Chairs will review which corporate risks will be considered by the digital committee going forwards in order that the digital committee will have oversight of corporate risks related to digital.

Other
The committee received assurance that the recruitment for a chief nursing information officer is underway

Recommendation
The Board is asked to **note** the contents of the report.

Report cover-page					
References					
Meeting title:	Board of directors				
Meeting date:	12/01/2023		**Agenda reference:**	**202-23**	
Report title:	Quality and governance committee assurance				
Sponsor:	Karen Norman, Committee Chair				
Author:	Karen Norman, Committee Chair Leonora May, Deputy company secretary				
Appendices:	None				
Executive summary					
Purpose of report:	The purpose of the report is to provide assurance on matters considered and discussed by the quality and governance committee at its meeting on 19 December 2022.				
Summary of key issues	• One serious incident in June 2021 • Numbers of patients awaiting clinical harm review reduced • Transferrable learning from three recent national investigations • A new patient safety risk- 1290 maintaining patient and staff safety in a post Covid-19 healthcare setting				
Recommendation:	The Board is asked to **note** the contents of the report, the assurance where given and risks identified.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	***World-class clinical services***	*Operational excellence*	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:	KSO3- outstanding patient experience- quality and supply issues with providers, ongoing workforce challenges KSO2- World class clinical services- restricted facilities to manage more complex patients				
Corporate risk register:	Committee deep dives on corporate risks Consideration of whether overarching risks should be added to the CRR Consideration of whether the vacant medical examiner post should be added to the CRR				
Regulation:	Health and Social Care Act 2008 CQC standards of quality and safety				
Legal:	As above				
Resources:	None				
Assurance route					
Previously considered by:	Quality and governance committee				
	Date:	19/12/22	Decision:		
Next steps:	N/A				

Report to:	Board Directors
Agenda item:	202-23
Date of meeting:	12 January 2023
Report from:	Karen Norman, Committee Chair
Report author:	Karen Norman, Committee Chair Leonora May, Deputy company secretary
Date of report:	20 December 2022
Appendices:	None

Quality and governance committee assurance

Introduction
This purpose of this report is to provide the Board with assurance on matters considered by the quality and governance committee at its meeting on 19 December 2022.

Clinical quality and patient safety
There had been one serious incident reported for the period and this was related to an incident in June 2021. Medication incidents remain the top incident reported and a deep dive has been completed into 'administration' errors. The committee accepted the recommendation that a quality improvement project on medication errors should be developed.

The committee received an update on clinical harm reviews and noted that engagement continues to improve with the implementation of the new process. The number of patients awaiting clinical harm review from 2021 has reduced during November and December, with 20% of the backlog completed. Recently there have been no patients identified as having suffered moderate or severe harm due to waiting more than 52 weeks, although the committee noted the number of breaches and fall in harm reviews for this year in comparison to last

The committee noted the findings of a recent audit on compliance with antimicrobial stewardship guidelines. Further work is required, particularly on documentation. The Medical Director is leading on this and a re-audit is planned.

The committee noted that there is reduced inpatient bed capacity due to planned maintenance work within the Canadian wing and a reduced on site presence for paediatricians, although they remain available for 24 hour telephone advice.

Infection prevention and control
The committee noted there was a Covid-19 outbreak in one of the wards on site which caused significant challenges.

The Covid-19 staff booster campaign was successful, with high numbers of staff having taken up the opportunity. The committee noted that the seasonal staff flu campaign is still running and that the team will continue to encourage medical staff to take up the opportunity.

Three cases of clostridium difficile infection (CDI) have been reported during the last quarter.

National investigation reports and transferrable learning from QVH

The committee received a report on transferrable learning from three recent national investigations: the Ockenden report 2 published 30 March 2022, the Kirkup report published 19 October 2022, and the investigation of concerns about quality and safety of mental health, learning disability and autism inpatient services in Manchester.

The committee noted the investigation findings and transferrable learning from incidents as set out within the report.

The committee agreed that there are some issues with staff escalating concerns and speaking up at QVH which is evidenced in current investigations, and requested a further updated action plan focussed on how the learning can be used to benefit QVH, specifically improvements to working culture and encouraging staff to speak up.

The updated action plan will be reviewed and discussed in detail by the Board at its seminar in February.

Risk
A new patient safety risk has been added to the corporate risk register: 1290 maintaining patient and staff safety in a post Covid-19 healthcare setting. This risk will be monitored and reviewed by the committee at future meetings.

Risk 1265: national Remifentanil shortage will be removed from the corporate risk register as the position has much improved.

Other

- The committee received the six monthly nursing workforce review report and noted that the Trust is considering options such as international recruitment and cost of living allowances. Assurance was taken with respect to safe staffing levels and safe care.
- The Committee recommended that the work started on an integrated performance perspective for the Board (paused due to the pandemic) should recommence.
- Sussex had not been impacted with the first wave of the Royal college of Nursing (RCN) strike action. The RCN will provide the Trust with notice should upcoming strike action affect QVH. The team have started gathering soft intelligence regarding which colleagues would or would not strike in order to manage staffing levels
- The committee completed its annual committee effectiveness review during November and the results of this were reported to the committee and discussed in detail at its seminar on 28 November 2022. A summary of the review will be presented to the Board in March 2023 as part of the Board effectiveness review
- Assurance was taken from the data presented within the patient experience report

Recommendation
The Board is asked to **note** the contents and recommendations of the report, the assurance where given and the risks identified.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**12/01/2023**		**Agenda reference:**	**211-23**	
Report title:	**Audit committee assurance update**				
Sponsor:	Kevin Gould, audit committee Chair				
Author:	Kevin Gould, audit committee Chair				
Appendices:	None				
Executive summary					
Purpose of report:	To provide assurance to the Board in relation to matters discussed at the audit committee meeting on 7 December 2022.				
Summary of key issues	The Committee received a report on the assurance framework for KSO 5 and the annual review of whistleblowing arrangements. A plan for the 2023 external audit was received from KPMG. Updates on Internal Audit and Counter Fraud were received from RSM.				
Recommendation:	The Board is asked to **note** the contents of this report.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO1: ***Outstanding patient experience***	KSO2: ***World-class clinical services***	KSO3: ***Operational excellence***	KSO4: ***Financial sustainability***	KSO5: ***Organisational excellence***
Implications					
Board assurance framework:	Internal audit reports were received and the assurance framework for KSO 5 was reviewed				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Audit committee				
	Date:	7/12/22	Decision:		
Next steps:	NA				

Report to:	Board Directors
Agenda item:	211-23
Date of meeting:	12 January 2023
Report from:	Kevin Gould, committee Chair
Report author:	Kevin Gould, committee Chair
Date of report:	3 January 2023
Appendices:	None

Audit committee report
Meeting held on 7 December 2022

1. The Committee received an update on the assurance framework for KSO 5 from the Interim Director of Workforce and OD and a verbal report from the Chair of the Finance and Performance Committee describing the assurance that committee receives on KSO 5.

2. The Committee received the annual review of whistleblowing arrangements and discussed the various mechanisms in place to facilitate the raising of concerns. There was further discussion on the themes being raised and on how these are addressed.

3. The Committee received the annual trust policy status report, noting the progress achieved but that there are still some policies outstanding for longer than 6 months.

4. The annual review of Standards of Business conduct policy and report of breaches was received. The Committee again noted challenges in getting full compliance. Further steps were agreed to increase compliance.

5. The Chair presented the results of the Committee's self-assessment, and the Terms of Reference were reviewed with minor changes proposed for approval by the Board.

6. KPMG presented an indicative plan for the Trust's 2022/23 audit and its final report on the 2021/22 audit of the QVH Charitable Fund.

7. RSM presented an update on the Internal Audit plan. Four reports had been completed since the previous meeting:
   - IT Clinical Systems (Partial Assurance, one High priority action)
   - Infection Control (Reasonable Assurance, no High priority actions)
   - Green Plan (Reasonable Assurance, no High priority actions)
   - Financial Sustainability (Advisory, no High priority actions)

   The Committee reviewed and discussed the outstanding management actions, noting the good progress that continues to be made.

8. The Committee received a report on the progress of Counter Fraud activity.

9. The Committee reviewed financial reports including details of waivers and invoices with no purchase order.

There were no other items requiring the attention of the Board.

Recommendation
The Board is asked to **note** the contents of the report.