Good Governance Institute

Working together
advice for governors and directors

Good Governance Institute (GGI)

February 2021

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NHS Foundation Trusts are required to develop a membership of people reflecting the communities they serve. In turn, these members elect the majority of members of the Council of Governors (some others are nominated by commissioners, local authorities and academic partners). Their role is to hold the non-executive directors individually and collectively to account for the performance of the board and to represent the interests of the members of the trust as a whole and the interests of the public. How? This Board Assurance Prompt is aimed at both governors and board members to help them to deliver this difficult brief. It consists of a narrative introduction and a set of Q cards for the nominations and appointments process, auditor appointments, significant transactions and holding to account. These are guides and cannot hope to be exhaustive!

One inescapable conclusion is that the tasks set for governors are difficult to fulfil. There is no single model that works across the range of different types and scale of Foundation Trust and Integrated Care Systems are a new challenge. Whilst governors will want to nod in the direction of their constituencies – patients, carers, local residents or staff – there is no ready made infrastructure for them to do so nor is it reasonable to divert NHS resources in the amounts that would make a difference. They will remain a group of self nominated individuals elected by an interested handful with a really important job to do.

The role of stakeholder governors, those nominated by closely affiliated organisations, should be embraced and acknowledged by the trust and the elected governors. Whilst elected governors take their authority and status from their constituencies it is important to recognise the perspective added by stakeholder governors. Stakeholder theory is based on an assumption that success is defined in relation to all stakeholders; in FT governance that must include all governors and those they represent.

A few definitions to start with. There is a difference between accountability and holding to account. Those accountable within the trust are responsible for delivering an outcome, can expect to be asked to explain or justify their actions and so be judged and then perhaps sanctioned or rewarded. For governors, holding to account involves receiving an account of actions taken and possibly further explanation or justification. They then are entitled to test the account by asking questions to come to a view on whether actions are correct, reasonable, justifiable in the circumstances or extensive enough and to give feedback. What, in the case of governors, it is not is being part of the management team or having any sort of line management relationship. Nor do governors have legal liability for the trust whereas the directors of the trust do and for the total performance of the trust. That said, accountability and holding to account are continuous processes. Provoking challenge and diversity of thought offers a way of avoiding "group think" in the decision takers. What governors offer works best when the roles are understood and distinctive.

A small, but important, quirk in all of this is that because the Council of Governors is chaired by the trust's chairman any meetings the Council holds are trust meetings, run by the trust and on agendas at least agreed by the trust if not instigated by it. Of course governors will expect to have a say in what their meetings discuss but it is a trust decision whether or not to take on issues raised by governors. If governors are concerned about an issue, raising it and receiving a response fulfils their duty. Deciding to take matters further with the board or more broadly is a different issue. The temptation to push an issue through different for a and media can be unhelpful and knowing when to stop is an important characteristic of being an effective governor

Most trusts elect a Lead Governor. The role finds its roots in Monitor (now NHSE/I) wanting an alternative way into a distressed trust but more positively, a lead governor can be a useful channel of communication between the council and the trust often in collaboration with the chair and trust secretary. Whilst the lead governor can be described as "first amongst equals" the Council remains a part of the trust and is chaired by the trust's chair.

There are a number of ways that governors can discharge their responsibilities. To a large extent they involve observation and questioning; whether that's talking to the board, patients or staff these opportunities are likely to be offered in a controlled environment. (It is not appropriate to give governors, or indeed non-executive directors, a licence to roam as much for patient confidentiality reasons as any other). Triangulating findings from these with the information trusts provide in their board and committee papers helps to round out the view governors form of the performance of the non-executive directors.

Board meetings take place in public and should be a part of a governor's timetable as should the meetings of the Council, which most trusts usually hold every quarter. Attending Council meetings is the only actual obligation for governors and needs to be taken seriously. Some trusts open their committee meetings to representatives of the council of governors – much to be encouraged though it needs the governors to commit to a feedback loop so all governors have the same information. Governors can participate in patient facing initiatives - for example PLACE inspections - and there are often other informal opportunities to find out what is going on and what people think about it.

Most Councils have governor working groups which help them to deepen their participation alongside helping the trust to meet some of its obligations. Governors are ideally placed to help trusts to build their representative membership and they have a role in advising the trust on strategy. A few trusts hold private, informal meetings between the directors and the governors partly to help to build relationships but mainly to give governors an opportunity to ask questions on topics of their choosing. If it is not possible to answer these at the time, we recommend that trusts follow up with answers as soon as they can. Most governors are also patients so their perspective on being a user of the trust and its facilities can bring a different perspective to the board's deliberations and should be listened to.

A sensible trust sees governors as a part of their governance arrangements and helps them to be critical friends and supporters. Briefing governors about thinking and plans means that when strategies become realities, the major transactions that can only proceed with governor support can be discussed and considered with the benefit of prior knowledge and understanding of the often complex thinking behind them. Working out how to become involved in the new ICDS arrangements locally will become crucial in the coming months especially as new legislation beds down.

In addition, trusts have an obligation to help with the development of governors to enable them to do their job well. Thorough induction is a good place to start. This should include attending the trust's staff induction programme, meetings with the trust chairman, trust secretary and the lead governor. These meetings are the opportunity for people to get to know one another and to establish existing skills and capabilities and of course any gaps. Some trusts pair new governors with more experienced colleagues and informal meeting of governors to exchange stories are also valuable. There are some more formal programmes available such as Governwell run by NHS Providers which help to uncover the mysteries of NHS financing as well as offering training in asking questions.

A final word on what is probably the most important role played by the Council of Governors – they recruit and appoint the non-executive directors including the chair of the trust. This explains why their principle statutory role is to hold that group individually and collectively to account. It is the job of the governors in general meeting to make these appointments and they do so following a recommendation from their nominations committee. They are not obliged to accept the recommendation but the rejection would need to stand up to scrutiny. Governors also approve the non-executive directors' choice of chief executive. There is no more important job for the Council of Governors than securing the future leadership, ensuring it is diverse and representative, and governance of their Foundation Trust; it sits at the heart of community involvement in the trust and must be treated with due respect.

Appraisals should feature in the nominations committee's work plan. It should receive a report from the chairman on the appraisals of the non-executive directors and have an opportunity to put in their views. The committee should also manage and receive the appraisal of the chair whether it is conducted by the senior independent director, if there is one, or undertaken externally. Agreeing objectives for the following year should be a part of this. These are important as they will play a part in the decision as to whether to offer any non-executive a second term of office – though nominations committees should bear in mind that the best contribution value from a non-executive comes from experience and knowledge of the trust and the NHS and so is not always apparent until the second term. The committee should report to the Council that they have reviewed the appraisals undertaken by the chair and also appraised the chair.

Nominations committees generally deal with remuneration for non-executives. It is not much of a task as there has been little change over the last few years and the levels of fee do not compare with the equivalent amounts paid in the private sector. Nevertheless, it is sensible to keep an eye on and participate in the various remuneration surveys run by NHS Providers and others. The usual health warning applies that if the survey is completed by the organisation then it is usually reliable; if the recipients fill in the forms then they may be subject to interpretation!

The future for Councils of Governors is interesting. Whilst there is no suggestion that there will be legislative change to dispose of them, as the Foundation Trust model itself loses influence so governor power could also fade. The collaborative mix is silent on community voice though some trusts with community links will already be embedded but this surely is an omission that will have to be addressed. Being able to demonstrate that the current model adds value today is essential. Qcard 5 discusses governor involvement in ICSs; it is important that governors are involved in wider governance; there are practicalities to consider as well as the contribution they can make as one of the expert local voices.

Q Card 1 – Nominations Committee

The make-up of the nominations committee will be described in the trust's constitution and usually involves a representative from each constituency who are elected by the governors from that group. It should be chaired by the trust chair and serviced by the trust secretary. The chief executive should expect to know about its considerations but has no right to participate. However, the committee can consult who it wishes to give advice including individuals such as independent reviewers, recruitment consultants and so on.

When appointing a new non-executive director the first step is to consider whether there are any particular capabilities or experience the Trust wants to capture in order to have a board of sufficient breadth. Whilst the basics of the job description are unlikely to change radically between appointments, the nuances of the person specification could vary considerably. This is also the moment to review the make and diversity of the board and to plan to take action if, as is the norm, this is necessary.

At this point, deciding whether to use an external recruitment firm should be discussed. Chosen wisely, a good head hunter can access individuals who may not respond to an advert, can undertake preliminary vetting of candidates and help to present the Trust to potential candidates positively. They can also be pivotal in helping boards to improve their diversity by actively searching for candidates from under represented backgrounds. How they are briefed is a key step especially when trying to ensure that the board is diverse in every possible way. The downsides of using an agency are cost – head hunting is not a cheap option – and being confident they understand the brief and approach and attract candidates of the right calibre can be a bit hit and miss. Be warned though, an advert can often bring a very large number of applicants whose interest has to be considered; this can be a hugely time consuming exercise.

You should expect to review a long list of all applicants divided into "looks appointable", "could be appointable" and "does not meet the brief". Your agency will probably have begun to speak to candidates and will already know some on the list. The committee should meet to agree a list of candidates for more detailed consideration leading to a shortlist of people to meet – probably no more than three or four. This final shortlisting meeting is one of the most important. The head hunters should have met the candidates by this stage and if you are not using advisers then the chairman and secretary should have been in touch. Once you are satisfied with the list you should plan to interview those shortlisted.

Opinion varies as to whether an interview is enough; all agree it is imperfect but most human processes share that description. You could ask for a short presentation or pre-notified discussion, add a stakeholder focus group of governors and senior trust staff to meet the candidates and you could run some psychometric tests. A word of warning on tests; non-executive directors should be recruited for a number of attributes and whilst personality "fit" might be important skills capability is less significant for this type of appointment. If a presentation is involved make it short and stick to the time allocation and do not use electronic powerpoint – it so often goes wrong and wastes time. A printed "leave behind" should suffice.

Inevitably there needs to be an interview. If the nominations committee is made up of a small number of people (say four or five) then all should be involved in asking questions. Each candidate should be invited to talk about the same subject areas so the interview plan needs to be discussed and agreed in advance.

You need to bear in mind just how complex the NHS is, especially its financing, and remember that the richness of the board means that some candidates will have little in depth knowledge so the questioning around this should focus on how they would develop what they need to know to be effective board members.

Typically the interview plan could include:

- A discussion about values and working with a values driven organisation is always useful especially with private sector candidates.
- Testing understanding of the difference between executive and non-executive responsibilities especially in the context of a unitary board where all directors sit as equals can be revealing
- How they would work with the board to change operating models – how would they choose the right priorities
- Working with stakeholders including governors, patients, commissioners is good to explore
- Collaboration, working with ambiguity and handling major projects are features of life in the NHS
- What will they need to do to get up to speed quickly from day one to be effective

The way into a discussion is by asking open questions – Tell me about a time… Can you give me an example of… What do you take into account when.. before following up on more specific issues. You need to listen actively and try to pick up on something the candidate has said to explore further so that you develop a conversation rather than a staccato version of twenty questions.

When you have interviewed all candidates, heard the views of the stakeholder focus group, looked at the test results, you are ready to make a recommendation. The secretary should then be asked to write an account of the session, setting out the process followed and making your recommendation which should then be put to the Council of Governors in general meeting for approval. The emphasis on process is important. The Council should reassure itself that its nominations committee has followed a good process, done it well so that the outcome is logical. Whilst there will always be an element of judgement in making appointments, being confident about how the recommendation was reached should be reassurance for all governors.

You can then make the appointment and the trust can begin the induction of its new non-executive director.

Finally, the process for appointing the chairman is no different except the person running the process should be either the SID or vice chair – provided neither is themselves a candidate. If they are, a non-executive director who is not in the running should be asked to take charge of the process.

Q Card 2 – Holding to Account

Although holding to account lies at the heart of what governors are asked to do it is probably the most difficult to deliver well. The combination of observing, questioning and assessing whilst remembering a governor is not part of the governance responsibility makes the balance difficult to achieve. Holding to account is about asking those accountable about the decisions they have made but it is not about being a part of that decision making.

In qualitative terms, what should governors be looking for:

- Leadership capability and capacity. Does the board have the right spread of skills, are the directors visible and approachable in the Trust and to governors? In practical terms are there succession plans in place. Often the layer below the executive directors is the one to focus on – could they run the trust if the executives were suddenly unable to – as a number of trusts found during the height of the pandemic
- Is there a clear vision and a credible strategy, designed following a thorough process involving staff and stakeholders – including governors. Could staff articulate the bones of the strategy and are plans lined up to deliver it. How well aligned is the Trust's strategy to the work taking place across local systems
- Is the board restlessly looking for change and improvement on both small and large scale. Is there a culture that encourages the delivery of high quality care and an atmosphere of kindness and empathy so patients really feel they come first
- Does the board spend time on strategic risk. Are its risk systems well organised and kept under review
- When things go wrong is the learning shared and disseminated across the whole organisation
- Staff – whilst you could spend all your time on staff issues governors should look for assurance that the trust is on top of any staff shortages, is working to improve diversity particularly amongst leaders and aspiring leaders and more particularly making and delivering plans in response to regular local and national staff surveys

These are based on some of the key lines of enquiry that the CQC uses to assess how well led it considers a trust to be. They are not the only criteria and in particular governors will want to put added focus onto patient matters. In a post Covid19 world, the impact on waiting lists and statutory targets will be the centre of attention of the board; dealing with reality rather than aspiration is essential. Learning from what has happened this year and adapting should be on the agenda. Many trusts have found ways to react with agility and speed and continuing to respond quickly and boldly would be a good outcome.

One of the most difficult aspects of holding to account is when things go wrong – eg a trust finds itself in regulatory difficulty, is hitting the press in the wrong way, several senior people leave at the same time etc. Governors should aim to be critical friends – find out and understand what has happened, support and if appropriate discuss and challenge the remediation plans and let go when the time comes. Above all, remember that people do not come to work to fail and make mistakes and NHS staff are almost all at work to do the right thing for their patients and families. The NHS tries to learn from its errors and avoid the "blame game" whilst not sidestepping accountability for actions taken – being a governance critical friend bringing different perspectives to issues is really valuable provided it is done positively and supportively.

Q Card 3 – Significant Transactions

By their nature, these do not happen very often. Trusts have the choice about whether to define significant transactions within their constitution; some have whilst others have not. In formal terms, anything described as a "significant" transaction requires 50% of the governors to support it. In reality, significant transactions are likely to relate to mergers and acquisitions, disposals of assets or major service lines and large scale commercial partnerships – this list is not exhaustive.

However, a significant transaction should not come as a surprise to governors. Wise boards will bring governors into their confidence as soon as they possibly can. It is worth reminding yourselves that governors are under the same confidentiality obligations as directors of the trust and behaviour in line with the Nolan principles is also to be assumed.

In assessing whether a transaction is in the interests of patients and the public at large, governors will be encouraged by their trust to take as broad a view as possible. The benefits of research may not be immediately apparent but the opportunity to take part in leading edge developments provides opportunities that will generally be a benefit. Setting up a smaller sub group to get to grips with more of the detail can be helpful and reassuring to the Council as a whole.

Governors will want to ensure that financial due diligence has taken place and that there is enough management band width to cope with the challenges of negotiating and completing the transaction and then to integrate and develop the new organisation. Regulators take a deep interest in mergers and acquisitions and governors can take considerable comfort from this and should ask about the process being undertaken.

Large scale deals are always moments to take a deep breath and making sure that the board has thought through all the issues thoroughly before concluding that the significant transaction is the right way forward is a crucial activity for the council of governors. Perhaps it is as well they do not come along very often!

Q Card 4 – Appointing the External Auditor

The governors are responsible for appointing the trust's external auditors, in collaboration with the trust which is responsible for managing the contract. Most trusts set up a task and finish group involving staff and governors to handle the process which takes place every 3-5 years. Auditors change so that they can retain their independence. They are also no longer allowed to provide other (more profitable) services to trusts at the same time as being auditor given the risk of conflicts of interest being created – they have to choose which they wish to undertake.

Independence is the hallmark of a successful external auditor; the trust's side of the bargain is overseen by the audit committee which will usually run the process to choose new auditors on the trust's behalf. It is worth testing at interview how the auditors view their independence and how they intend to preserve it at the same time as developing a good working relationship with the trust and its finance team. How they would interact with internal auditors is helpful to explore and how they have dealt with whistle blowing and fraud.

Q Card 5 – Working in the System

Delivery of care to patients and the way it is planned and paid for is changing. We are in the midst of a transition and the recent White Paper makes it clear that local Integrated Care Systems will be put onto a statutory footing with two boards: an ICS NHS board responsible for creating a local health needs plan and system-wide capital plan and securing provision and an ICS Health and Care partnership board responsible for drawing up a wider health and public health and social care needs plan which the ICS NHS board and local authorities will have to have regard to when making decisions. There will be a chief executive (also the accountable officer) a chief finance officer and others at the board's discretion. The key difference is that the current intention is that no institution involved will have the power of veto. Money – capital and revenue – planning, delivery and first line accountability for all services will sit with this group. It will be essential for governors to understand the changes to funding from activity based payments (although in abeyance presently due to the pandemic) to blended funding based on local population needs. Thinking through the implications of this especially as there is likely to be a single pot of money for each system with the ICS the body for financial delivery whilst accountability remains with trusts is a key priority – and not only for governors.

Providers will become part of a local collaborative but at the same time remaining accountable for their current range of formal and statutory responsibilities. Does this mark the end of any provider influence? We think not; there will be changes – FT "ownership" of its capital will end and their plans will be part of system wide arrangements; in a gesture towards diluting the duty laid on FT directors to act to promote the success of their organisation FTs will be permitted to form joint committees with other providers and participants and be authorised to deal with delegated decisions. But in a planned economy providers remain central to both local and specialised commissioning as well as delivering services as does the role of governors holding them to account. The indications are that we are moving towards a planned economy in which the role of the provider is central for both local and specialised commissioning.

More particularly, if change is coming working out how to run with it will be more positive than looking for ways to subvert it. Thinking needs to move away from the institution itself to the institution's role in delivery across the system. In other words from something defensive to something much more outcome focussed and seizing the opportunity to develop proactive focus on preventative health and deepening links into the community, primary care and education.

As a governor you have a duty to advise your own provider on their plans and should expect to do the same within the system even if for now how to do this is not centrally mandated or even described. This is the way to ensure that the finances will work properly and investment will be able to continue and your trust flourish. Reviewing how the plans are put into practice and to the quality aspired to forms the centre of your being able to hold your trust to account. Delivering across a local geography rather than just a part of it should provoke thinking about the contribution each constituent could and should be making. Being concerned for the population as a whole and as far as systems are concerned consulting people about change remains an obligation and not an option. Governors should encourage ICSs to talk openly and frankly to the people they serve and help this to happen perhaps by encouraging the establishment of engagement forums as well as formal consultations. No trust offers every service or pathway and so there should be improvements that your members benefit from as much as this being true of services your trust makes more readily available to others.

Matters to consider include:

- has your trust told you about the structure and direction of your local Integrated Care System and
- are your non executive directors locked into overseeing what the system is doing? As governors you need to be satisfied by asking at a Council meeting that your non executive directors are fully engaged so there is proper oversight of decisions being taken
- do you understand the governance implications of decisions being made and priorities set? For example, ICSs can delegate responsibilities and the White Paper suggests that non board members can be part of these committees. Is there proper oversight in place?
- are the long term outcomes clear?
- how is risk being dealt with? Financial risk with the change to the way payments are made and procedures are funded will undoubtedly raise concerns in the early years but there needs to be a thorough assessment of the benefits and risks from the actions being proposed and taken
- between all involved, the key adjustment to mindsets is to focus on overall outcomes because these are likely to bring with them changes to pathways – including where services are delivered – and therefore what patients experience
- as governors, being satisfied that these changes will lead to improvements overall across the geography covered by your ICS are central to what you are about. That said, thinking more broadly from the point of view of a local citizen or patient outside the confines of your hospital trust is what is actually being asked of you.

One of your obligations is to be concerned for the population as a whole and as far as systems are concerned consulting people about change remains an obligation and not an option. You should encourage ICSs to talk openly and frankly to the people they serve helping this to happen perhaps by encouraging the establishment of engagement forums as well as formal consultations when these are necessary.

Quality matters will also loom large; what is being done to deliver wider health outcomes; you will want to keep a watch over your own trust's performance whilst it plays a role in the system as a whole. Staff governors in particular should be asking about the impact of collaboration on the people in the trust; is the balance between change and continuity and how it affects staff being talked about and concerns addressed?

One of the system's responsibilities is the development of digital services including for the use of citizens. Your own trust may already have a digital programme and it will be important to understand how it fits into the broader picture – or perhaps how the broader picture fits into your programme. Everybody needs to find it within themselves to share experiences. These major programmes bring with them a need for cultural and behavioural change as well as making sure that working practices and digital solutions are in harmony and should include the patient perspective that governors can offer. These are areas to explore alongside the information governance implications of this agenda. However, digital solutions are not ends in themselves they are part of the solution to modernisation and operational challenge. They often have a long lead time and the procurement and investment decisions can be difficult and protracted and it is not easy to keep in view the overall objective.

One of the key sets of issues for governors seem likely to revolve around helping your trust to play a full part in the local system whilst retaining its own individual character. This is what has made successful trusts what they are, defines their position in the local community as well as, in some cases, exercising a broader influence through research and development, academic education and training and the specialised services it has developed. A trust's role in its community for example as a major employer is almost as significant as its healthcare responsibilities.

Keeping close to the board, your constituents and fellow governors is essential and insisting on having a way to express your views should be as important to the system's leadership as to your own trust.

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