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Code of governance for NHS provider trusts

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Contents

Equality and health inequalities statement.....	2
About this document.....	3
Introduction.....	4
1. Why is there a Code of Governance	4
2. What is new about this version of the code?.....	4
3. What is corporate governance?	7
4. What should trusts do to fulfil the code’s requirements of good governance?.....	8
5. How does the code fit with other NHS England requirements?	9
6. Further information.....	10
Section A: Board leadership and purpose	11
1. Principles	11
2. Provisions	12
Section B: Division of responsibilities	15
1. Principles	15
2. Provisions	16
Section C: Composition, succession and evaluation	20
1. Principles	20
2. Provisions for NHS foundation trusts board appointments.....	20
3. Provisions for NHS trust board appointments	23
4. Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts.....	23
5. Development, information and support.....	27
Section D: Audit, risk and internal control	31
1. Principles	31
2. Provisions	31
Section E: Remuneration.....	34
1. Principles	34
2. Provisions	35
Schedule A: Disclosure of corporate governance arrangements	38
Appendix A: Role of the trust secretary	62
Appendix B: Council of governors and role of the nominated lead governor	63
Appendix C: The code and other regulatory requirements	70

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](#)
- [Working together at scale: guidance on provider collaboratives](#)
- The wider suite of [Integrated care systems: guidance](#)

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](#) (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.¹

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, which will evolve particularly for 2023/24. Under this new framework we intend to continue to treat

¹ [Integrated Care Systems: design framework](#), p30

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 England² 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](#).

² 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.

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 leadership 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 its "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](#).
- 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.³

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](#)
- [Guidance on good governance and collaboration under the NHS provider licence](#)
- [Your statutory duties: A reference guide for NHS foundation trust governors](#)
- [Foundation trust councils of governors and system working and collaboration: An addendum to your statutory duties – A reference guide for NHS foundation trust governors](#)
- [Director-governor interaction in NHS foundation trusts: A best practice guide for boards of directors](#)
- [The Healthy NHS Board 2013 – Principles for good governance](#)
- [The seven 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:](#) developed by CIPFA (the Chartered Institute of Public Finance Accountants), this guide gives advice on the roles of chairs and board members.

³ This is updated on a yearly basis and published on [our website](#).

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,⁴ and that risk is managed effectively. The board should regularly review the trust's performance in these areas against

⁴ 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.

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.⁵
- 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.

⁵ 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](#). 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.

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 appointment⁶
- 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

⁶ 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.

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](#).

- 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.⁷ 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,

⁷ For more information refer to the Equality Act 2010, The NHS' successive Equality Delivery Systems (EDS) and the NHS Workforce Race Equality Standard (WRES).

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](#).

- 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](#) 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](#) and an [Addendum to Your statutory duties – A 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 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](#).
- 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](#) 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](#).

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](#), 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](#) and NHS trusts should also follow [Guidance on senior appointments in NHS trusts](#).
- 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.⁸
- 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.

⁸ For further information on conflicts of interest see [Managing conflicts of interest in the NHS: Guidance for staff and organisations](#).

- 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](#).
 - 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.⁹
 - 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

⁹ 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.

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](#) 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.

Provision	Requirement
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

Provision	Requirement
	<p>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.</p>
Section B, 2.6	<p>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:</p> <ul style="list-style-type: none"> • 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.

Provision	Requirement
	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, 2.19 (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

Provision	Requirement
	annual report and a statement made about any connection it has with the trust or individual directors.
Section C, 4.13	<p>The annual report should describe the work of the nominations committee(s), including:</p> <ul style="list-style-type: none"> • 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	<p>The annual report should include:</p> <ul style="list-style-type: none"> • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed

Provision	Requirement
	<ul style="list-style-type: none"> • 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

Provision	Requirement
	uncertainties regarding going concern. Trusts should refer to the <i>DHSC group accounting manual</i> and <i>NHS foundation trust annual reporting manual</i> 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.

Provision	Requirement
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

Provision	Requirement
	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

Provision	Requirement
	<p>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.</p>
<p>Section A, 2.9</p>	<p>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.</p>
<p>Section A, 2.10</p>	<p>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.</p>
<p>Section A, 2.11</p>	<p>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.</p>
<p>Section B, 2.1</p>	<p>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.</p>
<p>Section B, 2.2</p>	<p>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.</p>
<p>Section B, 2.3</p>	<p>The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive</p>

Provision	Requirement
	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.

Provision	Requirement
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.

Provision	Requirement
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, 2.18	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, 2.19	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

Provision	Requirement
	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.

Provision	Requirement
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

Provision	Requirement
	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.

Provision	Requirement
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)	<p>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:</p> <ul style="list-style-type: none"> • 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. <p>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.</p>
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

Provision	Requirement
	<p>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.</p>
<p>Section C, 4.11</p>	<p>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.</p>
<p>Section C, 4.12</p>	<p>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.</p>
<p>Section C, 5.1</p>	<p>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.</p>
<p>Section C, 5.2</p>	<p>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</p>

Provision	Requirement
	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

Provision	Requirement
	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.

Provision	Requirement
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 C, 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

Provision	Requirement
	<p>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.</p>
Section C, 2.2	<p>The main roles and responsibilities of the audit committee should include:</p> <ul style="list-style-type: none"> • 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.

Provision	Requirement
Section D, 2.3	<p>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.</p>
Section D, 2.5	<p>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.</p>
Section E, 2.1	<p>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.</p> <ul style="list-style-type: none"> • 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

Provision	Requirement
	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.

Provision	Requirement
Section C, 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

Provision	Requirement
(NHS foundation trusts only)	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.

Provision	Requirement
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

Provision	Requirement
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*](#) (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* (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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