Foundation Trust Network

New voices
new accountabilities

A guide to wider governance in foundation trusts

Working on behalf of the NHS

hosted by THE NHS CONFEDERATION
FTN is a membership organisation open to authorised and aspirant foundation trusts. Established in June 2004, it works to **represent** the views of foundation trusts, to **influence** health policy and to **share learning and good practice**, both within the FT movement and with the rest of the NHS. The FTN is hosted by the **NHS Confederation** but our work programme is steered by an **independent board** elected by our members.

For further information about the Foundation Trust Network, visit [www.foundationtrustnetwork.org](http://www.foundationtrustnetwork.org). FTN members can access copies of all the case study material submitted for this guide on the members area of the site.
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Foundation trusts are a new kind of organisation in the UK’s public services. Based on mutual traditions, they have been established as ‘public benefit corporations’, with new freedoms to innovate and forge partnerships in the public interest and governance arrangements designed to help trusts better reflect the needs of the communities they serve.

First set up in April 2004 following the acrimonious passage of the enabling legislation through Parliament, the rigours of the financial regime under which foundation trusts operate has often taken centre stage. However, the new model of governance being pioneered by foundation trusts should not be overlooked. Less than 18 months in, it is already clear that it both represents one of the most significant challenges of foundation trust status and has the potential to herald some of the most far-reaching reform. At best, it is the beginnings of the transformation from the top-down monolithic NHS created in 1945 towards locally-owned organisations driven by local priorities, responsive to local needs and delivering higher quality services to patients as a result.

This guide throws the spotlight on these wider governance arrangements. Based on case studies from the first wave of foundation trusts, it looks at how they are recruiting and involving members and working with their new boards of governors.

The legislation that brought foundation trusts into being was deliberately broad brush, setting only minimum requirements to enable individual organisations to design arrangements to fit local circumstances. Given the diversity of foundation trusts – from district general hospitals to specialist trusts, from those serving local populations to national and international constituencies – it is not surprising that diversity is the hallmark of the approaches that have subsequently emerged.

Introduction

The purpose of this guide is not to select out one particular approach and declare it best practice for all. The aim is rather to draw out some of the practical challenges and lessons from what has been developed so far, and to highlight evidence of the successes achieved.

It is still early days, with many foundation trusts operating for only a matter of months. But the evidence in these case studies suggests the new governance arrangements are an emerging strength. We hope this will be a useful guide to the work that is underway, not least to enable aspirant trusts waiting in the wings to benefit from the lessons and successes of the first wave.

The report starts by highlighting some common themes that guide the wider governance efforts of foundation trusts, based on our case study material and discussions with authorised trusts. By way of introduction, it goes on to give a recap on how foundation trusts operate before reviewing some of the new challenges facing FT boards of directors. Two sections then explore membership and governance in turn.

The first section on membership explores the ways in which members have been recruited and engaged in the life of the trust, including a look at some of the practical challenges involved. The section on governance sets the scene by looking at how trusts have created their constitutions before focusing on how boards of governors have been established, including the different models emerging for the governor role. It concludes with a look at the position of company secretary – a new but potentially vital part of the FT governance arrangements.

We then review the experience of first wave trusts in running governor elections before turning to a view from Monitor on how they will assess wider governance as part of the compliance regime. The guide ends with an assessment from first wave trusts themselves of the emerging benefits of wider governance.
Less than eighteen months into the life of foundation trusts, the wider governance structures are still developing and bedding in. The case studies in this guide underline that there will be a number of different models that fit the circumstances of any particular foundation trust as a result of the stakeholders it must engage and the services it provides. However, despite this diversity, it is possible to draw out some common themes that guide the way that foundation trusts are developing their governance models.

**Flexibility and diversity**
Foundation trusts are trying to make the governance arrangements in the Act work. However, the model it outlines does not fit all foundation trusts, particularly those with a national or international focus. Flexibility and diversity is essential to building a wider governance structure appropriate to the needs of the particular trust and its stakeholders. Future waves should be free to draw their stakeholder map and populate their membership and governance constituencies – as long as they satisfy the regulator that they are creating governance structures that are fit for purpose.

**Inclusion**
Many foundation trusts are putting considerable effort into trying to ensure that their membership is representative of the communities they serve. An increasing number are developing sophisticated analyses of their membership profile in order to target their recruitment efforts, and some are exploring innovative ways to engage traditionally ‘hard to reach’ groups. However, foundation trusts have also learnt that with a system of democratic election, there is no means of guaranteeing the inclusiveness of their governor boards.

**Clarity**
All foundation trusts would stress the need for participants in the wider governance arrangements to be clear about their role. This requires further work to develop and clarify the role of governors and a shared understanding of the different roles and purpose of the board of directors and board of governors.

**Engagement**
Many foundation trusts are working with governors to open up dialogues, to involve them on issues of concern and to listen carefully to their views to inform board decision making. While the initial wave of membership recruitment inevitably focused on establishing a broad membership base, an increasing number of trusts are now focusing their efforts on providing genuine opportunities for member engagement.

**Communication**
All foundation trusts recognise the need to give governors the information they require to properly carry out their function and the importance of ongoing communications with their members to build the relationship over time.

**Learning**
Foundation trusts want to learn how to continuously and successfully evolve practice in wider governance both by working with their members and governors and by learning from their colleagues elsewhere.
The enabling legislation for foundation trusts, set out in the Health and Social Care (Community Health and Standards) Act came into force in November 2003. The first 10 foundation trusts were authorised by Monitor, the new independent regulator, on 1 April 2004. Since then, 32 foundation trusts have been authorised in three successive waves, with the most recent cohort receiving the green light from Monitor in April 2005. The government has made a commitment that all NHS trusts will have the opportunity to apply for foundation status by 2008, and there are now over 30 trusts preparing for the next phase of the roll-out to take place.

Foundation trusts remain part of the NHS family and retain a duty to treat patients according to NHS quality standards and principles - free care based on need, not ability to pay. However, three key features make them distinct from other NHS trusts.

Firstly, foundation trusts have been established as public benefit corporations - a new legal entity which draws on mutual traditions. Each foundation trust has a duty to consult and involve a board of governors - comprising patients, staff, members of the public and other key stakeholders - in the strategic planning of the organisation. Governors in turn are accountable to members of the trust - patients, carers, staff and members of the public - who can stand and vote in elections to the board. These new governance structures require foundation trusts to actively engage their stakeholders in shaping plans to make health services more responsive to the needs of individual patients and the health needs of the communities they serve.

Secondly, with new accountabilities in place to their local community, foundation trusts have been set free from Whitehall command and control. They are no longer subject to direction from the Secretary of State and while they must operate to national healthcare standards and targets, they are not performance managed through strategic health authorities. Self-standing, self-governing entities, free to determine their own future, it is the board of directors that takes full responsibility for the governance of the trust.

As part of this shift, new financial freedoms have also been granted to foundation trusts. No longer required to break even each year, trusts may retain any operating surpluses to invest in the delivery of new services. They have greater scope to raise capital from both the public and private sectors within borrowing limits determined by projected cash flows. While their assets remain in the public sector, foundation trusts are free to innovate as their boards see fit and to form partnerships across all sectors of the economy in the public interest.

Finally, foundation trusts have a new regulator, Monitor, responsible for authorising, monitoring and regulating these new public benefit corporations. To qualify for authorisation, applicants must pass Monitor’s assessment process and demonstrate that they are legally constituted, financially viable and sustainable, and well-managed. The terms of the authorisation set out the conditions under which the foundation trust must operate, including the services they can provide, the amount of income they can earn from private charges and their borrowing limit.

Once established, foundation trusts must report to Monitor, initially on a quarterly basis, to ensure they comply with their authorisation. The compliance regime aims to be risk-based, with well-governed, high-performing trusts given space to exercise their freedoms. However, where trusts are experiencing major problems, oversight will be more intensive and Monitor has extensive powers to intervene if a significant breach of the authorisation is judged to have taken place.

These three changes - in governance, in the operational and financial framework, and in the regulatory regime - are what make foundation trusts unique. The first wave of foundation trusts are now testing out what this new model can deliver.

How foundation trusts operate

The enabling legislation for foundation trusts, set in out the Health and Social Care (Community Health and Standards) Act came into force in November 2003. The first 10 foundation trusts were authorised by Monitor, the new independent regulator, on 1 April 2004. Since then, 32 foundation trusts have been authorised in three successive waves, with the most recent cohort receiving the green light from Monitor in April 2005. The government has made a commitment that all NHS trusts will have the opportunity to apply for foundation status by 2008, and there are now over 30 trusts preparing for the next phase of the roll-out to take place.

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Foundation trust boards of directors are fundamentally different from their counterparts in the rest of the NHS. As self-standing, self-governing entities, they have responsibilities and liabilities comparable with the private sector, together with public sector accountabilities.

This is a huge transition for organisations that have been run by powerful chief executives managing upwards to the command of Whitehall, to become self-determining organisations focusing outwards in a system driven by patient choice. It requires a serious commitment and skill level from both executive and non-executive directors that is different in kind from anything NHS organisations have required in the past.

**New roles**

Boards of directors will increasingly have to operate as corporate entities, not sounding boards, in a world of contestable service provision. This requires a fundamental change in the role of all members of the board.

The chair has a pivotal position in the governance of foundation trusts, not just the chief executive. They provide leadership and guidance to the chief executive, and, as chairs of the board of governors, are the key link between the governors and directors. It is the chair’s job to unite the constituent parts of the governance model to ensure the two boards work effectively together.

Executive directors must make the transition from operating as functional heads of service to members of a corporate board, bearing the full weight of the fiduciary responsibility that falls on their shoulders and contributing fully to the strategic decision-making of the trust.

Non-executives face an equally significant change. As their traditional role as guardian of the community interest is increasingly transferred to the board of governors, non-executives in foundation trusts must take equal responsibility and accountability for the function and success of the business.

**New responsibilities**

Foundation trust boards of directors also have new challenges to face and additional responsibilities. They must become strategic decision-makers responsible for the direction of the business, and will be required to forge new partnerships in the public interest and to innovate to deliver services more responsive to patient needs.

As new organisations operating in a healthcare economy that is itself undergoing massive change, risk management has become central to the successful governance of foundation trusts. In a choice-based system where money follows the patient, foundation trusts are required to set three-year forecasts in the context of uncertain income streams and to effectively manage their new borrowing freedoms. Robust reporting procedures and proactive scrutiny of financial performance is essential if trusts are to flourish in this more volatile financial regime.

While financial risk has been under the spotlight so far, foundation trusts must also demonstrate their effective management of clinical risk, alongside all the other risks associated with running organisations of a size and complexity to rival FTSE 250 companies.

Freed from top-down performance management from the Department of Health, boards of directors need to be self-evaluating of their own performance and capable of performance managing the organisation to achieve excellence.

Effective stakeholder management is similarly vital. As public benefit corporations, foundation trusts are faced with a complex set of relationships and accountabilities: to the board of governors; to the wider membership and local community; to PCTs as commissioners of their services; and to Monitor as the regulator. Managing these multiple accountabilities in an effective and transparent way and building strong relationships must be at the top of the agenda of the foundation trust board.

To survive and thrive in this new world, foundation trusts must build a team of directors with the skills to take on these new challenges. This may require enhancing the board’s expertise in areas ranging from financial analysis and investment appraisal, to business development, marketing and stakeholder relationship management.

It is against the backdrop of this transformation in the role of the corporate board that the new wider governance arrangements to which we now turn are taking shape.
Introduction
Membership is central to the mutual model on which foundation trusts are based. By giving staff, patients, partners and the public a real stake in their organisation, foundation trusts have been set the challenge of transforming themselves into outward-facing, locally owned organisations which can deliver better services to their communities as a result.

This section looks at how the first wave trusts have responded to this challenge. It looks first at how they set about consulting their stakeholders and how they devised their membership strategies. It then turns to their experience of membership recruitment and the approaches trusts have adopted to ensure their members reflect the diversity of the communities they serve. It looks at the practical issues involved in setting up and maintaining the register of members and the different ways in which trusts have sought to develop an ongoing relationship with their members over time. In conclusion, it turns to some of the emerging lessons and policy implications of this first phase of membership recruitment and development.

Consulting on foundation status
In order to receive Secretary of State approval to apply for authorisation, applicant trusts must be able to demonstrate that they have effectively consulted their stakeholders about their vision for foundation status.

This consultation process has usually started with preliminary, informal discussions with other organisations in the health economy and local partners and community groups to test their views. A formal consultation process is then set in motion, focusing on the trust’s vision for foundation status and its proposed model of governance, including the design of its membership constituencies.

The case studies below illustrate the wide range of consultation methodologies used, ranging from road shows and public meetings to radio and television advertising. Feedback from the first wave suggests that one of the most effective strategies has been to visit local community groups and to speak at pre-existing public meetings, rather than stand-alone consultation events.

Another key reflection from trusts that have gone through the process is a recognition of the value of effectively mapping stakeholders from the outset. Investing effort in effectively engaging stakeholders early in the process was vital in building their support and relationship with the foundation trust over the longer-term.

Queen Victoria Hospital NHS Foundation Trust
“Queen Victoria published a consultation document which was sent to NHS partners, stakeholders and individuals and was also available in public buildings in all our four counties.

For consultation with our NHS partners and stakeholders, the chief executive spoke at numerous board and other meetings, including the West Sussex Health Scrutiny Committee, to set out our vision. This strategy was particularly successful as we engaged the membership of other stakeholders.

We adopted various methods to consult with the public including roadshows, our website, telephone campaigns, shopping centre walkabouts and on-site publicity. Media awareness was raised via a series of radio advertisements on commercial stations in all four counties and a newspaper advertising campaign. The chief executive met and spoke at a series of meetings hosted by local interest groups, such as the League of Friends and the QVH Patient Forum. Public meetings were well attended, particularly because they were often linked to the meetings of other organisations such as the Rotary Club.

Internally, there were a large number of discussions about the implications of the
freedom of information and data protection acts. We utilized the patient database to contact people individually, when we were confident that this was permissible. There were also a series of staff meetings to consult and inform internally. The consultation document itself invited people to sign up as foundation trust members.

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The vision emphasised ‘your local hospital, your local specialist’ and how it was going to develop with the new freedoms. It was this unique selling point of the Queen Victoria Hospital which actively sold the membership rather than the foundation trust process.

**Barnsley Hospital NHS Foundation Trust**

“We set out to be as informative and approachable as possible in consulting our local community about foundation trust status. We used diverse methodologies as the process progressed – from an initial awareness raising exercise using local media (press and radio), through distribution of information leaflets across the local and neighbouring areas, face-to-face contact with staff, public and stakeholders by attending or holding meetings across the community and staffing information stands at supermarkets and shopping centres.

In addition, we established a series of working and reference groups to help us through the process – from our initial expression of interest to our final application. The groups included representatives of patients and the public, local and regional health and social care organisations, education, staff, volunteers, trade unions, voluntary groups, management and non-executives. All the main issues in the consultation document, the governance framework and the constitution were initiated or reviewed through these groups and our Trust Board.

We issued 90,000 information leaflets and 5,000 copies of our consultation document to a health community of approximately 200,000.”

**Cambridge NHS Foundation Trust**

“In developing our foundation trust application we held a number of events to bring together stakeholders from our local health and social care community, unions, staff members, and representatives from education, research and regional bodies. Stakeholder organisations for consultation where mapped against key constituency areas including patient groups, groups for the elderly, youth panels, ethnic minority groups and special interest groups.

Engagement in the development of the governance structures, including the membership of the board of governors, was discussed and subject to formal public consultation. This early work built stakeholder relationships and support for the foundation trust at an early stage, helping to develop relationships that have flourished as the board of governors has developed.

One of the primary stakeholder relationships was with the staff of the Trust and University who could become members. An internal communications campaign, website, face to face staff briefings and staff focus group were tools used to ensure the key messages associated with foundation trust status were communicated.

As part of the consultation process, the Trust also:

- produced and distributed a public document outlining the Trust’s reasons for wishing to apply for foundation trust status and its suggested composition for board of governors and membership constituencies to over 2000 organisations and individuals (including city and county councils, parish councils, local education establishments, PCTs and other NHS and health bodies)
- held eleven consultation meetings around the proposed membership area, comprising a presentation on the proposals followed by questions and answers
- attended a wide variety of meetings (including voluntary groups and the local authority overview and scrutiny committee) to present proposals
- organised displays in key locations such as local shopping centres and supermarkets
- distributed an expression of interest document to over 124,000 households.”
Devising your membership strategy

Devising a membership strategy is an early task for organisations preparing for authorisation. Each strategy will clearly be distinct to reflect the trust’s particular business model and stakeholder profile, ranging from district hospitals and specialist trusts serving predominantly local populations to specialist and university trusts with a national and international reach.

However, membership strategies are likely to cover similar themes. They are likely to establish the trust’s vision for membership and the objectives it is seeking to achieve, define the membership constituencies and whether staff and patients will opt in or out, set a target for membership recruitment, and outline how the trust intends to engage members and develop relationships over the longer term.

This section looks at three key parts of the membership strategy in turn: the objectives trusts have set at the outset, how they have designed their membership constituencies, and decisions on staff and patient opt in or opt out.

Setting objectives

Royal Devon and Exeter NHS Foundation Trust

“Royal Devon and Exeter’s membership development strategy was built around a number of strategic objectives. These were to:

• define the membership community and ensure this is reflected in the council of governors
• recruit 10% of our core population (350,000) over five years
• develop an understanding of the levels of involvement members wish to have – and to link this to member activities
• develop communication strategies for members and member recruitment
• develop the governors’ role in membership recruitment
• develop an understanding within the trust of the value of FT status and membership
• link membership with existing PPI activity.”

Doncaster and Bassetlaw Hospitals NHS Foundation Trust

“Our membership development strategy:

• sets out our view of the role of foundation trust members
• defines our membership community

• looks at how we will resource membership development
• sets out our objectives for membership recruitment
• outlines how we will manage an active membership and communicate with members
• sets out our plans for playing a community role and making foundation status distinctive
• says how the strategy will be evaluated.

Our objectives included commitments to:

• widen membership to all members of our qualifying communities
• provide a simple, accessible and publicised process for becoming a member
• strive for the composition of the membership to reflect the diversity of the local communities in which the trust operates
• encourage employees to remain in membership
• increase the number of active, informed members who are representative of the trust’s patients, staff and local communities
• ensure members receive appropriate, user friendly and timely information about the trust in order to make informed decisions
• recognise and use members as a valuable resource, unique to a mutual organisation.”

Designing constituencies

A key part of the membership strategy is to define the membership community and to design appropriate constituencies. Under the Act, applicant trusts are given considerable freedom to tailor the membership arrangements to reflect the nature of the organisation and the communities it serves.

While trusts must ensure constituencies reflect local authority electoral boundaries, trusts need to decide how to break down their public constituency. The most straightforward approach is to mirror the local authority wards for those areas within the official catchment area. However, most trusts will have patients from outside areas and need to decide whether the numbers are significant enough to warrant being represented by a governor. Three case studies below demonstrate some of the different approaches taken in Wave 1.

While trusts are required to have two constituencies for staff and for the public, they are free to decide whether to have a constituency for patients. Unsurprisingly, Wave 1 trusts have again made different decisions. Trusts providing specialist services are more likely to have established a patients’ constituency to enable them to bring into membership patients from a wide geographical area who have received care from the trust. Trusts whose services focus predominantly on secondary care from a district
hospital site often felt that most patients were resident in the public constituencies and that having two separate categories would cause too much overlap.

Divisions of the staff constituency have ranged from those who have established separate classes for different professional groups (clinical/non-clinical or more specific breakdowns such as medical/dental, nurses/midwives, allied healthcare professionals, hotel/estates, A&C/managers etc) to those that have opted to classify staff according to the hospital site at which they are based.

While the Act sets no age requirements for membership eligibility, the vast majority of trusts set minimum age limits for membership (and therefore voting), ranging from 11-18.

All these decisions were the subject of discussion with key stakeholders, with a number of trusts reporting amendments to their initial proposals as a result of the consultation process.

While these final designs for membership constituencies must be submitted as part of the application process, the experience of first wave trusts suggests that authorisation is not the end of the process. The fact that some first wave trusts are already reviewing their constituencies in the light of new referral patterns is a reminder that defining the membership community is an ongoing process, to be reviewed over time as foundation trusts develop new business models and partnerships and respond to the dynamic of patient choice.

Homerton University Hospital NHS Foundation Trust

"Homerton University Hospital is situated in the east London Borough of Hackney and serves the populations of Hackney, the City of London and surrounding boroughs. We have three public constituencies (Hackney, City of London and Outer) and two staff constituencies (clinical and non-clinical).

The public constituencies reflect the areas from which our patients come. As the hospital for Hackney, we were keen to involve any member of the public who wanted to be involved, rather than just patients, and therefore, as an organisation, we originally chose not to have a separate patient constituency.

One year on, we are considering extending the public constituencies beyond their current geographical boundaries to reflect our expanding referral patterns. This issue will be discussed by our constitutional review group, to be established shortly and expected to include both governors and directors with professional advice on constitutional law."

Basildon and Thurrock University Hospitals NHS Foundation Trust

“There was strong support for our local membership constituencies as set out in our consultation document. We initially proposed that we would have a separate patient constituency for the area outside of our local public constituencies. However, because of the potential confusion and overlap between the public and patient constituencies, we decided to combine them. The four public constituencies are for people resident in the council areas of Basildon, Thurrock, Brentwood and the rest of Essex; the latter to take account of the opening of the Essex Cardiothoracic Centre in 2007.

On staff membership, following analysis and discussion with colleagues, staff and their representatives on the Trust Negotiating Committee and Staff Council, we decided not to progress with the suggestion of dividing staff into constituencies defined by professional groups. As we are on a split site, we decided instead to define the constituencies by place of work, with one for staff based at Orsett Hospital and the other for staff based at Basildon Hospital and other sites.

We were initially one of the few trusts to propose no lower age limit for membership. During consultation this received a high level of support, although concerns were raised as to how very young members might participate. Consequently, we set a lower age limit of 12 for membership, with the undertaking that we would ensure younger children have a way of expressing their views."
Opt in or opt out?

Another key decision to be made in finalising the membership strategy is whether to adopt an opt-out or opt-in system for membership of the staff or patient constituency.

Most trusts in the first wave adopted an opt-in approach for patients, based on the view that this would be more likely to attract members who had made an informed decision to join and would therefore encourage a more active and engaged membership.

A small number of trusts decided on an opt-out approach to maximise the opportunity for those with a pre-existing relationship with the trust to engage and participate. While this succeeded in delivering a large and representative membership very quickly, the trusts have now adopted an opt-in approach to encourage greater engagement and to enable resources to be focused on developing a relationship with those who have already joined.

The approaches taken to staff are more varied. Initially, a number of trusts adopted an opt-in approach to staff at the outset, to encourage individuals to actively decide to join and recognise the benefits of membership.

A majority of trusts took the view that there should be an opt-out system for staff to reflect the fact that employees are an integral part of the trust and have an automatic interest and stake in its activities and right to participate.

A number of trusts now provide an opt-in regime for current staff but have an opt-out process for new staff, on the basis that when an individual starts their employment it is known that FT membership is a fundamental part of their contract. Others are in the process of converting from an opt-in to an opt-out approach across the board in response to staff consultation.

Recruiting members

Many of the first wave trusts were faced with the challenge of consulting with their local communities while the legislation was still being amended in Parliament. This meant their communication strategies focused on building awareness and understanding of foundation status rather than direct membership recruitment. Later applicants have been able to use the consultation process as a more explicit start of their drive to encourage staff, patients and the public to join the trust.

Applicant trusts are not given a membership size that they must achieve. As a result, there has been a great deal of variation between trusts in the size of membership they have set out to recruit. Across the first wave, membership numbers at the time of elections to boards of governors varied from 1,122 to 96,174.

Recruitment methods have varied, but many trusts have used a similar core set of techniques illustrated by the case studies below. Two methods in particular have emerged as the most successful in generating inquiries and membership applications: direct mail and face-to-face recruitment, often linked to hospital sites. While both approaches are expensive and time consuming, the returns were high, with mailshots generating returns ranging from 3-6%. Reflecting their experience of the consultation phase, many trusts found that building recruitment activities into pre-existing events was also a useful recruitment tool.

Basildon and Thurrock University Hospitals NHS Foundation Trust

“We used a variety of methods to ensure we reached all stakeholders, such as local media advertising and editorial, local council publications, leafleting and events. We have worked closely with our local PPI Forum, CVS, patient and resident groups and have specifically taken the following actions in order to recruit members:

- taken a road show to local shopping centres during NHS Week and exploited other opportunities to take foundation membership out to the public
• approached patients and members of the public on hospital sites
• sent letters from the chairman inviting patients to join alongside information on appointments
• sent application forms with all initial contact letters following GP referral
• run a membership recruitment stand at a trust open day
• visited local support groups and attended public meetings
• placed advertisements in the local press
• continually improved our membership leaflets to ensure they are easy to read and understand.

The two most efficient and effective recruitment methods we have found are direct mail to patients and face-to-face approaches which enable members of the public to ask questions and fully understand the benefits. This has given us a reasonable spread in terms of gender and ethnicity, less so geographically and, perhaps inevitably, a bias towards older age groups."

Liverpool Women’s NHS Foundation Trust

"Liverpool Women’s NHS Foundation Trust ensured that membership recruitment activities were built into events held both inside and outside of the trust. For example, on the trust site, Donny Osmond’s visit to promote the trust’s 10th anniversary appeal was tied into membership recruitment activity. Off-site, the trust had a clear presence at health-related events held in the community, e.g. Liverpool’s Big Heart Festival, an annual ‘Fun in the Park’ event held by a local health forum, and even piggy-backed onto promotional events in the local supermarket calendar with a recruitment drive during Asda’s ‘Baby Week’.”

Homerton University Hospital NHS Foundation Trust

"Most of the techniques we employed to recruit members prior to April 2004 are still used. These include:

• A range of bespoke publicity literature for internal and external use (posters, flyers, leaflets, recruitment stands, membership application boxes), as well as the generic literature provided by the Department of Health. Posters, leaflets and application forms have been forwarded to and are displayed in GP surgeries, opticians, PCT premises, neighbouring PALS, community pharmacies and local authority information points. All literature and advertising makes use of a freepost address.

• Consultations, visits and outreach - very few people attended our three public consultation meetings. However we wrote to over 1000 local community groups and continue to visit these to discuss hospital issues on a more targeted basis. The hospital has attended some community groups with advocates to ensure effective translation of information into community languages. Governors from these communities advise on the most effective mechanisms for this.

• Membership stands - our governors attend local community events to discuss membership issues with the public.

• Mailings - letters and application forms to patients outlining the benefits of membership have proved to be the best way of recruiting members in large numbers. To date this has been undertaken twice, initially to 30,000 and latterly to 5,000 recent patients.

• Proactive use of local and national media opportunities.

• Information pages in local newspapers - the local free newspaper in Hackney is delivered to all households and has proved to be the most effective method of contacting the public in this area. The hospital regularly purchases advertorial space to reach the whole population on matters relating to hospital services and membership.

• Website - although many of our members tell us that they do not have access to the internet, there is a membership section on the hospital website including on-line membership applications and dedicated email addresses for the public to talk to governors.

• Open day - in celebration of our first year as a foundation trust, we held our first open day. This was well attended by members and the public. A membership stall was manned by governors and over 40 members volunteered to help on the day. The volunteering alone was a way that we could get to know some of the members better.

• Refer-a-friend initiative - members and governors tell us that they want to tell others about the benefits of membership and, in response to these comments, we have developed a refer-a-friend scheme for this.

All methods have been effective in some measure. However it is the combination of all the methods working together that is important. Undoubtedly the most effective method has been the mailshots to large numbers of patients with an uptake rate of 3%. This however continues to be the most resource intensive and costly method employed.”
Building a representative membership

While many trusts’ initial recruitment drives inevitably focused on membership numbers, the overriding requirement in the Act is for trusts to ‘take steps to secure that their membership is representative of those eligible to join.’ Similarly, under Monitor’s compliance regime, trusts are required to demonstrate they have a clear strategy to achieve representative membership as part of their annual plan submission.

Trusts are now working hard to broaden their membership profile. Many are using software programmes to analyse the age, gender, ethnicity and socio-economic profile of their membership compared with the profile of their catchment areas. Armed with this information, successive waves of recruitment drives are becoming increasingly targeted at under-represented groups. Recognising the older age bias in many trust membership profiles, work to tailor recruitment materials and methods to attract young people is increasingly high on the agenda of a number of first wave trusts.

ACORN profile of Harrogate and District NHSFT Membership

Experience to date also suggests some of the complexities of striving to secure representative wider governance structures. Trusts have inevitably found their members to be more representative of their patient population rather than the wider public that they serve. Many in the first wave have also learnt that even with a representative membership in place, a system of democratic election means there is no way of guaranteeing the inclusiveness of their governor boards.

The Campaign Company: building a representative membership

“All Trusts strive to achieve the most representative membership possible. But there are barriers to achieving this. People who become members with minimal prompting (by responding to direct mail for example) are most likely to be of a certain age, ethnicity and social class. To achieve a genuinely representative membership, it is necessary to reach out to those who are less likely to respond to traditional approaches. Messages need to be conveyed in a culturally sensitive way, and using a combination of recruitment methods to reflect the varied nature of the potential membership.

‘Recruiting the recruiters’ - i.e. engaging those citizens that are already active in the community is a vital starting point for increasing the membership. Such people can be encouraged to not only join themselves but also to act as agents to interest the members of their organisations in joining as well. Similarly, ‘Member get member’ campaigns with appropriate materials and incentives for the recruitment of friends, colleagues and families of members are effective means of enlarging the membership community.”

Harrogate and District NHS Foundation Trust

“Harrogate and District NHS Foundation Trust has had the socio-economic profile of our membership assessed against ACORN profiles (see pie chart). This will enable the trust to target membership activity to create a membership reflective of all socio-economic groups, geographical areas, ethnicity, age and gender.

We also aim to understand the socio-economic profile of our active members. The Trust holds an annual open evening event, which over 800 people attended last year. We are exploring the possibility of scanning attendance of members with their ID number so that we can analyse the membership profile, along with those members who register their interest for PPI activities.”

Homerton University Hospital NHS Foundation Trust

“Over many years the hospital has developed strong links with local communities through the community leaders representing many of the ethnic groups which make up the Hackney community. This has helped us to develop a membership truly representative of the community, and we have found the strength of communication by ‘word of mouth’ cannot be underestimated.

Prior to April 2004 our foundation team visited many of these community groups to discuss the value of membership and the opportunities that foundation trust status offered, and we continue with these visits today.

Our public governors broadly reflect our local communities with representatives from the Orthodox Jewish, Turkish, Asian and Afro-Caribbean communities; some, but not all of them are the community leaders we had already developed relationships with. They are our link into, and spokespeople for, our communities and are always willing to accompany us on visits and presentations to local groups. One year on, the governors are beginning to undertake formal presentations themselves on the benefits of membership.
To ensure that our membership reflects the diversity of our local population we have purchased software from Active Total Solution Mapping (www.totalsolutionmapping.com) which allows us to plot members against local census data, by post code, ethnic group, age, sex, etc. This has proved very useful in enabling us to analyse our membership profile. At present we find that our membership is broadly representative of the local community (see graph below). However we assess this regularly through the software and could target specific groups for membership if required.

Active membership from our communities is important to us and members from many diverse backgrounds have volunteered, and participate in, our members’ forums and discussion groups. We have also received requests from members from some of our local minority ethnic communities to extend our series of monthly health education talks to focus on health issues for specific ethnic groups and we are at present considering how best to do this.”

Papworth Hospital NHS Foundation Trust

“The Rotherham NHS Foundation Trust is working on targeted recruitment activities to increase membership among young people, women, and black and minority ethnic communities. This includes a pilot project to establish and support a group of ‘membership champions’ for the trust, who will act as advocates to increase membership in a sustainable and cost-effective way. The membership sub-committee of the governing body is leading this work to recruit membership champions and to then support them in the task of recruiting more members. They are putting in place communications and systems for rewarding and recognising this work to ensure that it is successful and sustained. The learning from the pilot will be applied to the whole membership community next year.”

Engaging young people

The Rotherham NHS Foundation Trust

“In the run up to our application for foundation trust status it was identified that we needed to increase public membership. It was also identified that inevitably the majority of our existing membership came from the over 40’s section of the local population.

Having identified the need to both quickly increase membership and to address imbalances in our membership demographic it was decided to look for outside assistance in our recruitment.

We worked with an external consultancy to carry out a targeted recruitment drive including telephone and face-to-face methods. This included targeting specific postal codes and approaching younger people face-to-face. The membership was increased by 2,000 in one month and the age and geographical imbalances rectified.

We believe it was a cost-effective exercise, with recruitment averaging approximately £4 per head. However, having succeeded in our initial recruitment drive, the real challenge will come in engaging the younger membership in the workings and governance of the trust.”

Stockport NHS Foundation Trust

“Stockport NHS Foundation Trust has set up a young people’s engagement sub-group to the board of governors to advise on effective ways of engaging young people in strategic planning and service delivery and to act as a forum for listening to the views of young people. It has appointed a young person governor who has forged links with schools and the LEA to create a youth associate membership for under 16’s.”

Cambridge University Hospitals NHS Foundation Trust

“Cambridge University Hospitals NHS Foundation Trust has produced a youth communications strategy and is planning to develop recruitment material targeted at young people. An outreach programme is in place, focusing on schools and colleges (including talks in assemblies and to relevant subject groups), relevant clinics and departments and youth volunteers and cadets.”

Barnsley Hospital NHS Foundation Trust

“Barnsley Hospital NHS Foundation Trust is working with the existing structures for youth representation – the Barnsley Youth Council – to ensure that they are aware of the new foundation trust governance arrangements and to encourage membership and participation among young people in the area.”
The membership application form

Many trusts in the first wave found that the initial membership recruitment form has taken a number of iterations to get right as organisations have become clearer about the information they need.

Authorised trusts suggest the core details required are:
- member’s name
- address
- home/work/mobile telephone number
- e-mail address
- date of birth or age category (date of birth makes ongoing analysis easier)
- ethnicity
- gender
- constituency they wish to join
- whether individuals are happy for their name to appear on the public register
- preferred method of contact.

Additional information that many trusts have subsequently collected includes:
- Desired level of involvement (for example, receiving the member newsletter, attending the annual members’ meeting or other events, responding to surveys and consultations, volunteering, standing for election etc)
- Special interests.

A number of trusts have focused their membership form only on the core information required to keep it as simple and quick to fill in as possible. Members who join are then sent a welcome pack with further questions on their desired level of involvement or special interests to provide an additional opportunity to engage the new member.

Creating your member register

All foundation trusts are required to establish registers of members, directors and governors. These registers must as a minimum contain a list of names and, in the case of the director register, state their interests. The Department of Health assesses plans to create the register of members as part of the application process and expects the registers to be operated ‘as cost effectively as possible’. Following authorisation, foundation trusts must ensure their register of members is maintained in a way which complies with regulations laid in 2004 and must provide membership data to Monitor as part of the Annual Plan process.

The key distinction in the approaches trusts have adopted for their member register is between those who have chosen to establish and maintain it in-house, versus those who have opted to use an outside agency. There are strong advocates of both approaches.

Those in favour of in-house arrangements believe it gives them greater ownership and control over their membership strategy and facilitates integration with wider patient and public involvement activities. Those who have opted to go out-of-house often feel that it has freed up membership staff to focus on more strategic membership development work and enabled greater efficiencies to be achieved, particularly in handling major mail-outs and producing membership reports. Claims of greater cost-effectiveness are made on both sides.

Irrespective of where register maintenance takes place, a majority of first wave trusts have set up in-house membership offices to ensure they can receive incoming calls from members. For many, this has proved to be a vital way of developing a more personalised relationship with their membership and an opportunity to engage members more effectively in the activities of the trust.

Despite the diversity of approaches taken, there is one thing that unites many authorised FTs: a recognition that effective member register management requires a commitment of resources at the outset. Trusts often found that their initial database was inadequate when faced with growing membership numbers and the need to record more information to develop their membership strategy. As a result, many then had to spend considerable time establishing more effective in or out-of-house arrangements capable of handling the amount of data and degree of functionality required.

Trusts that have invested in their database have found that it is more than a register of members: it is a customer relationship management tool that is at the heart of their efforts to develop targeted, two-way communications with their members and to build these relationships over time.
Below, Computershare – one of the companies used by trusts to maintain their registers – provides a perspective on what member register management entails, before we look at two sets of case studies which illustrate the different approaches taken.

1 NHS Foundation Trusts: A guide to developing governance arrangements, Department of Health, Sept 2004, Section 9, page 2
2 Compliance Framework, Monitor, March 2005, p12

Developing your member register: a view from Computershare

"Once the membership is in place, it is critical that the register of members is maintained according to best practice. The membership register is not a static database of names and addresses but an ever-changing register of real people and the Trust has made a commitment to work with, engage, inform and listen to them.

Members will die, move house, no longer wish to be members and have detailed enquiries about elections, governors, Trust strategy and operational issues. Membership register management should therefore be seen not as a database of names to be recorded but management of the relationship between the Trust and its many thousands (or tens of thousands) of members.

The necessary actions required are:
- address verification against post-code data ensuring that members are in the correct constituencies and contain accurate postcode information in order to benefit from postal discounts
- de-duplication of the register and cross duplication verification with the staff member database
- regular checks against the National Change of Address register to enable amendment of the records where members have moved without notifying the Trust
- checks against multiple bereavement registers to reduce the risk of mailing to deceased members
- provision of suitable resources to deal with members’ enquiries that are likely to peak when certain activities such as elections, newsletter mailings or recruitment activities occur
- provision of membership packs to provide members with key information about the foundation trust in addition to contact details where further information can be obtained
- the ability to analyse the profile of the membership against the profile of the constituency in order to ensure that the membership is representative of the constituency in terms of age, gender, ethnicity and socio-economic profile."

Managing your member register in-house

Basildon and Thurrock University Hospitals NHS Foundation Trust

“One of our key membership aims is to ensure that we maintain an accurate and informative database of members to meet regulatory requirements and to provide a tool for developing membership, and to recognise and use members as a valuable resource, unique to a mutual organisation.

To this end, we explored and evaluated the various options for database management. Initially, we set up an Access database which was developed in-house. Within a very short period of time, it was apparent that we needed to look for a more sophisticated package. The following issues and questions needed to be addressed:

- to consider and compare in-house and out-of-house options
- to compare the costs of both
- to compare functionality and compatibility of software packages
- can the same level of member contact and control be offered by both choices?
- can software be tailored to suit our specific needs?
- will the software supplier migrate our current data onto the new system and resolve any data transfer problems?
- can the software supplier offer initial and on-going support?

Having worked with the IT department and compared the different packages, it was clear that the in-house option was preferable to out-of-house. It was more cost effective - a one-off cost of the licence compared to increasing and recurrent annual costs; we retained control of the database and could provide a local point of contact for members; and reporting would be available at no additional expense.

Having taken into account all of the above, we chose an in-house Customer Relationship Management (CRM) software solution called Goldmine and a local company (www.webefficient.co.uk) to customise it for us as an existing local supplier with whom we already had a positive and supportive working relationship. We believe this CRM database management tool has provided a very sound base from which to grow and develop our membership and member involvement.”
Homerton University Hospital NHS Foundation Trust

“We manage all membership on an in-house basis. We chose to do this as we wanted to ensure that membership remained local and relevant to our differing communities. This is now administered through the membership office. At the present time we employ one membership development officer as part of the corporate affairs team; thus providing an integrated governance function.

The in-house database we use is now robust and holds all the information we require. It is easy to use and allows multiple users to have access. The membership development officer administers the database.

Members are actively encouraged to drop in or call. As the service develops, we may need to review this but we believe that an on-site membership office works best for our members.”

Managing your member register out-of-house

Harrogate and District NHS Foundation Trust

“Harrogate and District NHS Foundation Trust has outsourced our membership management to Computershare. We serve a population of 183,000 and have a present membership of 10,600 members with an ‘opt in’ scheme for both staff and the public. We have a vision to grow our membership to 20,000 over five years.

We want to maintain an accurate database at all times. We have systems in place to screen death registers and house moves prior to mailing and we update our staff database on a monthly basis with starters and leavers.

There is a website link to the membership form online with a direct link to update the membership database. Reference to this is published on all communication to members to encourage new members to join using this method. Computershare run a call centre help line for us which is also widely publicised.

The database is multi-functional. For election purposes, each member receives postal communication. However, for all other communications we have asked members to state their preferred method, resulting in 1,800 members opting for electronic communication via a broadcast email and a further 770 opting to share hard copies of information within their household (reducing our postal distribution costs by 25%). We can also reliably track how many members have opened their electronic communication. Hard copies through the post are pre-sorted to the postman’s delivery round to enable the Trust to access a postage discount.

The bulk ordering and storage of stationary is also financially more advantageous than within the NHS and we can print a strap line message on envelopes to reduce the image of junk mail.

To enable the trust to develop membership activity to support patient and public involvement, our database holds fields for clinical areas of interest alongside preferred method of communication and involvement. This will enable all future communication with members to acknowledge their area of interest and any relevant activities.”

Derby Hospitals NHS Foundation Trust

“Within the Derby Hospitals NHS Foundation Trust, our member database is currently split into two registers, one for staff members, and the other for public members. Both of these, until now, have been managed internally.

In the case of the staff members’ database, this is administered through our human resources function as they are in a position to automatically handle staff changes.

Our public database has been managed within the secretariat office. However, this is to change following the decision to engage Computershare in a membership drive, where all the responses will be handled by them and incorporated onto the database, using their systems. This was considered the most appropriate way forward, as part of the arrangement offered by Computershare will be to undertake regular checks to ensure the data held is up to date by monitoring the various public registers.

It was also considered that outsourcing the management of the public database would enable the skills and expertise of the membership manager to focus on higher value activities, rather than routine database tasks. This in itself would enable economies of scale to be achieved at a lower cost than the trust could deliver if it were managing the public membership itself.

At present the transition has yet to be completed, however, the success of this new arrangement will be monitored closely.”
Ongoing membership engagement

Once the challenge of recruiting an initial membership is complete and the member register established, foundation trusts have had to focus their energies on sustaining the interest of their members and developing a longer-term engagement strategy.

A crucial part of this has been to understand more about the level of involvement members want. A number of trusts have now carried out surveys to gather this information and have stratified their membership to ensure subsequent communications are more targeted. Many trusts have incorporated questions about desired level of engagement into a revised version of their membership application form to collect this information from the outset.

Faced with small in-house staff resources, limited budgets and membership numbers often above 10,000, the challenge of establishing an ongoing relationship with members is no easy task. For trusts with memberships at the higher end of the spectrum, postage costs alone make regular mailings difficult. While a few trusts have succeeded in gaining advertising in their member newsletter to help cover some of these costs, ensuring sufficient resources are in place to underpin regular communications remains a real issue for trusts in the first wave.

Despite these resource constraints, a wide range of methods to build relationships with members are now being tested out. Member newsletters are the key tool being used to ensure a regular programme of communications is in place. Opportunities for getting actively involved include attending governor meetings and the annual members’ meetings; open days, health lectures, and other public events; participating in consultations, patient panels, and critical readers groups; and volunteering to work in the hospital or help with fundraising activities.

As discussed in more detail in the next section on governors, trusts are also exploring ways to bring governors and members together through constituency-based meetings and focus groups on key issues like access to services, cleanliness and patient information.

Cambridge University Hospitals NHS Foundation Trust

“Members have:
- been involved with five focus groups (see page 24)
- attended a series of ongoing lectures by specialist speakers entitled ‘medicine for members’
- been engaged with the trust’s current ‘wayfinding project’ to improve signage around the hospital and at other stages of the patient journey
- met and engaged with governors at member/governor events throughout the membership area and the trust
- assisted with the production of the ‘rights and responsibilities of members’ policy’
- elected the elected members of the board of governors.”

Queen Victoria Hospital NHS Foundation Trust

“We produce a quarterly newsletter which gives people an opportunity to put forward ideas of things they would like to know more about. The newsletter was used to follow up the response from members on application that they wished to be actively involved and invited members to become lay members on working groups and committees. Each newsletter receives approximately 100 follow ups.”

Chesterfield Royal Hospital NHS Foundation Trust

“Members of Chesterfield Royal Hospital NHS Foundation Trust are playing their part in influencing a major change to the way the hospital runs. A combined total of almost 10,000 staff and community members have had the opportunity to offer their views on new proposals to control visiting hours and restrict the number of visitors per patient. The plans are part of an overall campaign to make the hospital cleaner and safer - and by controlling visiting, helping to reduce hospital-acquired infection.

A staggering 40% of members have responded to the consultation, which ran for just two weeks and was sent out to home addresses. 99% of respondents felt the local community should also take some responsibility to help to reduce infection, and 94% agreed that visiting hours should be reduced.

Results from the exercise will be used by governors, the hospital’s management committee and board of directors to make a decision about what new visiting hours the hospital adopts.”
Homerton University Hospital NHS Foundation Trust

“All members receive quarterly members’ newsletters. Membership cards have proved popular, with members reporting that this gives them a sense of belonging to the organisation. They have also requested membership numbers which we had not used initially.

Our clinical nurse specialists run a series of health talks on a monthly basis for members. Subjects such as MRSA, diabetes, allergy and asthma, prostate cancer, and looking after your heart have been covered so far.

The number of requests from departments requiring members of the public to become involved in various projects is increasing. Foundation members are actively involved in visits to improve our hospital environment and cleanliness initiatives. They are also bringing a patient perspective to nurse and other clinical staff training days, and in inpatient services reviews.

In late 2004 we undertook a survey of members to identify those areas that members wished to become more actively involved in. The options were:

- participating in council of governors meetings
- participating in public meetings
- participating in annual members’ meetings
- participating in patient panels for surveys
- attending health talks for members
- attending community surgeries
- standing for election as a governor in the future
- volunteering in the hospital
- recruiting new members
- fundraising
- receiving information only.

10% of members responded to the questionnaire and we are now using this information to inform our involvement strategies and membership development work.

Under the guidance of the membership development committee, we have started work on the following initiatives:

- members’ forums and governor surgeries (see page 24)
- annual members’ meeting - our first annual members’ meeting will take place in September. Historically attendance at AGMs has been very poor. However there were approximately 300 members at the last AGM and we anticipate that the interest from members will continue.”
Emerging issues

With the majority of foundation trusts in existence for less than a year, these case studies suggest that great strides have already been made in recruiting and developing relationships with members and that much has already been learnt.

Given that foundation trusts range from district hospitals predominantly serving their local communities to major teaching hospitals with an international reach, it is no surprise that a diversity of membership strategies have emerged.

Ensuring the trust has a clear view about the role of members and how they can add value is vital to give meaning and coherence to the membership strategy. Trusts with an agreed vision from the outset of the benefits of membership are in turn better able to ensure members themselves understand their purpose and contribution.

The case studies demonstrate the varied ways in which the member role is now being developed. From participating in consultations, focus groups and patient panels, to volunteering, fundraising and attending lectures and events, members have been a new resource that can be tapped to ensure the trust is more responsive and accountable to those it serves.

However, these emerging successes must be set against some of the constraints within which trusts are operating and the challenges ahead.

Perhaps the most recurring theme from Wave 1 is the need to ensure resources are in place to invest in the membership from the outset. Faced with limited budgets and staff that often have membership development alongside their other pre-existing responsibilities, many trusts have been extremely restricted in the membership communications they can deliver in practice. Recognising the business case for investing in the membership – not least as a source of competitive advantage in the context of patient choice – is going to be crucial to success over the longer term.

Trusts’ limited membership budgets also underline the points already made about balancing quantity of members with the quality of the relationship. Trusts need a sufficiently broad and representative membership to underpin the legitimacy of the wider governance arrangements. However, they must also ensure membership is of a size that enables the trust to resource an ongoing dialogue and real opportunities to get involved. While the initial focus of membership strategies was inevitably on membership numbers, the case studies suggest that many trusts now feel they need to devote more resources to target traditionally ‘hard to reach’ groups and to engage their existing membership, rather than simply aiming for membership growth.

Nearly 18 months in, the policy implications of the first round of membership recruitment are also becoming clear. While foundation trusts are trying to make the governance arrangements in the Act work, its one size approach simply does not fit all, particularly for trusts with a national or international focus. In the future, foundation trusts need to be free to draw their own stakeholder map and to populate their membership and governance constituencies to reflect their stakeholder profiles and business models. It will then be for individual trusts to satisfy the regulator that their structures are fit for purpose and meet their statutory duty to govern themselves properly.

The need for greater flexibility in the governance model is underlined by looking ahead to the next cohort of applicants waiting in the wings. Some foundation trusts are already having to define their geographical boundaries for membership to ensure they do not compete with FTs serving the same constituencies. As the number of foundation trusts grow, there may well need to be a sensible rationalisation of the wider governance arrangements to avoid trusts trying to recruit amongst the same populations and causing confusion as a result. This may mean the development of ‘foundation systems’ within geographical areas that allow individual foundation trusts to co-operate to access stakeholder engagement.

It is still early days for this experiment in public engagement. While in a few areas good practice is becoming clear, for the most part first wave trusts are still testing what works. A key task ahead will be to ensure trusts have robust measures of success in place and can demonstrate the effectiveness of the strategies they have chosen. Some of these measures are already set out in Monitor’s compliance regime: membership size and growth, voter turnout, and evidence of a representative membership profile. But the challenge over this next phase will be to develop richer criteria that reflect the views of members themselves and their level of engagement, as well as an evidence base that demonstrates their impact on the business models being developed and the quality of care patients receive.
Developing the constitution

The Health and Social Care Act 2003 requires each foundation trust, as a public benefit corporation, to have a constitution. Schedule 1 sets out minimum statutory requirements with which every constitution must comply. This includes provisions on the eligibility criteria for membership and the designation of membership constituencies, the operation of the board of governors and board of directors, and provisions for dealing with conflicts of interest.

Applicant trusts must submit their proposed constitution to Monitor for approval as part of the authorisation process. Once authorised, the legality of the constitution is one of five elements of governance that will be considered in Monitor’s annual ratings assessment, with any amendments to the constitution requiring the regulator’s approval.

Developing an effective and robust constitution is clearly an essential part of the process of establishing sound governance arrangements for a foundation trust. Ensuring clarity of roles from the outset for each element of the governance structure has been recognised as particularly critical by trusts that have gone through the process.

However, while many of the constitutions of first wave foundation trusts drew on a template issued by the Department of Health, as new organisations, there is little to guide applicant trusts in drawing up their constitutions outside the framework of the 2003 Act. This lack of accompanying guidance is particularly stark in comparison with the role of the Company Acts, the Listing Rules and the Combined Code in providing the body of governance practice for publicly listed companies.

Monitor and the Department of Health are working together with the aim of publishing a model core constitution. This will meet the authorisation requirements while allowing scope for individual trusts to vary other key elements to reflect their own circumstances. The document will be available on Monitor’s website following a consultation process with key stakeholders. It is hoped that this will be in place for the next wave of trusts applying for foundation trust status.

This new framework constitution will enable applicants to draw on the emerging best practice from existing foundation trusts about the key constitutional elements required to underpin good governance.

The task for the next wave of applicant trusts will be to draw on this core constitution whilst ensuring the process remains locally owned and focused on a genuine dialogue with stakeholders about how the governance arrangements can be designed to reflect local circumstances and views.

Cambridge University Hospitals NHS Foundation Trust

“Writing the constitution of a new organisation required detailed thought about the purpose and function of each aspect of the governance structure. The principles we applied to this process were:

- **Simplicity:** keep the governance structure as simple and understandable as possible within the framework of the legislation. This was essential if the organisation was to be democratic and accessible – its constitution needed to be understood.

- **Veracity:** ensuring that the constitution, in its attribution of roles and responsibilities, reflected the way the organisation would actually deal with any issues that arose. How would we handle a situation where a member became disqualified from membership? How should the role of carers be reflected in the constitution?

- **Clarity:** individuals taking on new roles, particularly governors, needed to be reassured about some basic principles such as 'Do I have any personal financial liability?', ‘What is the time commitment of the role?’

The most important issue to be clear about within the constitution was the relationship between the board of governors and the board of directors. It was vital to ensure that the role of each group was explicitly defined in the constitution as this drove the subsequent definition of their respective responsibilities.
The support of an experienced legal team with knowledge of both existing NHS governance structures and corporate governance in the broader perspective was essential. It ensured we had reflected all statutory requirements appropriately (not just those in the 2003 Act) and allowed us to learn from good practice in the NHS and current developments in the wider corporate governance arena."

The board of governors

Enabling patients, the public and staff members to elect representatives to the board of governors is how foundation trusts bring the interests and views of stakeholders into the very heart of the organisation’s governance.

Consulting on the composition of the board of governors, ensuring a broad and representative membership base for governor elections, and supporting governors as they establish their role has been a major challenge for first wave trusts.

This section first looks at different models for the board of governors before exploring the variety of ways in which the governor role is being developed. It looks at the relationships that have been established between governors and the board of directors, and the training and support for governors which is being put in place. It concludes by drawing out some of the recurring themes from the experiences of foundation trusts to date.

Models for the board of governors

The Act gives foundation trusts significant scope to shape their board of governors. As a result, a wide diversity of models have been established to reflect the different nature of foundation trusts as organisations, the services they provide and the profile of their communities.

The size of boards of governors is one of the most obvious sources of variation: while the majority had memberships of between 30 and 40, the smallest has only 18 members and the largest 53. Those who have opted for larger boards of governors believe this inclusiveness has provided a broader spectrum of experience and expertise and strengthens the likelihood that the board will reflect the diversity of the communities it represents. Trusts with smaller boards of governors feel this has made the board of governors less unwieldy and made it easier to have discussions where everyone has an input.

Terminology has also proved to be important. Many trusts have felt that adopting the title ‘board of governors’ from the legislation could exacerbate the potential to confuse the role of the two boards. As a result, just over half of the first wave have opted for the title council of members or council of governors to highlight the different role of governors in representing stakeholder interests to the board of directors, rather than taking responsibility for the day to day operation of the organisation.

The case studies below illustrate some of these different approaches.

**University Hospital Birmingham NHS Foundation Trust**

“UHB has 37 people on their board of governors, comprising:

- 13 public governors from the parliamentary constituencies in Birmingham
- Six patient governors
- Five staff governors (medical, nursing (two governors), clinical scientist/allied health professional, ancillary administrative and other staff class)
- 13 stakeholder governors

The stakeholder governors involve strong representation of key specialist skills sourced by nomination from major organisations in the life of the city. These skills, and access via these to the relevant professional and community groups, were considered essential ingredients for a successful foundation trust board of governors. Key stakeholder bodies within the NHS, local government and education are also present and relationships with these organisations are also extremely significant.”

**Royal Devon and Exeter NHS Foundation Trust**

“The Royal Devon and Exeter provides secondary and tertiary services to a population of approximately 750,000 which is largely rural and highly dispersed. Our 36-strong council of governors has 19 public governors with four from mid Devon, six from Exeter, six from East Devon and three from the rest of Devon, Dorset, Somerset, Cornwall and the Isles of Scilly – a division that represents proportional representation by commissioning PCT.”
The staff community elects five governors (medical/dental, nurses/midwives, allied healthcare professionals, hotel/estates, A&C/manager). The appointed governors comprises four nominated by our PCTs, five from our local authorities, one from our medical school and two appointed by Exeter Council for Voluntary Services.

**Stockport NHS Foundation Trust**

"Stockport’s 39-strong board of governors comprises:

- Twenty public governors – 16 from Stockport, three from the High Peak and one Outer Area
- Six staff governors, comprising two nurses/midwives, one allied health, one doctor and two from other staff groups
- Thirteen appointed partner governors, including
  - three PCT
  - one patient forum
  - one young person
  - two educational
  - two voluntary sector
  - two local authority
  - two enterprise (Stockport Chamber of Commerce and Small Businesses Federation)

Decisions about the composition of the board reflect the priorities of the trust. For example, the inclusion of two educational governors is part of Stockport’s developing links with local education services in order to provide training packages for healthcare workers. Including a young person’s governor has been part of our drive to establish new links with local schools and to work with them on the concept of corporate citizenship."

**Developing the role of governors**

Governors are given a number of statutory roles in the enabling legislation for foundation trusts, namely:

- appointing, removing and deciding the terms of office, including the remuneration, of the chairman and other non-executive directors
- approving the appointment of the chief executive
- appointing or removing trust auditors
- reviewing the annual accounts, auditor’s report and annual report at a general meetings
- expressing a view on the board of directors’ forward plans.

Guidance from the Department of Health makes clear that the board of governors’ responsibility is to ensure foundation trusts respond to the needs and preferences of stakeholders, with day-to-day operational management remaining the preserve of the board of directors. However, little further detail is provided about the governor role.

A number of models are now beginning to emerge beyond the bare bones of these statutorily defined responsibilities. Four ways of working above and beyond these formal duties are already clear from the experience of first wave trusts:

- influencing policy and strategy
- leading member focus groups
- membership recruitment and development
- community outreach.

While there is clearly overlap between these roles, they do begin to illustrate the diversity of models being developed, with many trusts drawing on all of these approaches. The case studies below illustrate each of them in turn, starting with governors’ formally defined role.
Developing the statutory role

The responsibility of boards of governors to appoint the chair and non-executive directors is the most practical and visible expression of their new role in the trust’s governance.

Many boards of governors have already had experience of the appointments process for non-executives, and a small number have appointed chairs. The case study below highlights the way the process has worked in one first wave trust.

Countess of Chester Hospital NHS Foundation Trust

“We have made two appointments since becoming a foundation trust: a non-executive director with a financial background and a new chairman. The nominations committee of the council of members has played a crucial role in both cases.

In accordance with our constitution, about six months before the vacancy arises, the board of directors determines the job description and person specification with particular attention on the expertise required for each vacancy in order to balance the board. Once agreed, this is circulated to the council of members. We have handled both appointments in-house and tried to raise awareness of the opportunity by using local and regional business networks, the members’ newsletter and press releases, as well as advertising in the local press.

The nominations committee comprises the chairman (or appropriate non-executive director for the chairman appointment), a public elected member, a staff elected member and an appointed member along with the chairman of another NHSFt acting as an external assessor. The committee meets to shortlist. The selection process comprises two parts. Firstly, an informal meeting with the board of directors, and then a formal interview with the nominations committee. In each case, to date, only one name has gone forward to the council of members. However the council of members makes the decision whether to appoint or not at a formal meeting.

We are currently reviewing our process to see how it can be improved. However we believe we have made an encouraging start with two excellent appointments.”

Influencing policy and strategy

Developing the annual forward plan which foundation trusts must submit to Monitor has been an important process for testing governors’ influencing role, with directors required to demonstrate that they have ‘had regard’ to the views of board of governors in drawing up their forward plans.

A number of trusts have held joint planning days to discuss the service development strategy and the annual plan, and in these trusts, this is now becoming an established way of ensuring governor perspectives and priorities are reflected in the strategic decision-making of the organisation.

Other ways of enabling governors to develop their influencing role are also being explored. One of the most common is the setting up of sub-groups based around governor interests or areas identified from the service development strategy. While these sub-groups are often in their early stages of development, they are increasingly providing a forum for governors to scrutinise existing services and plans and to give their views.

University Hospital Birmingham NHS Foundation Trust

“For the development of this year’s annual plan UHB was able to incorporate the views and opinions of our governors through a revised process which has resulted in a robust plan for the next 12 months, approved by the board of directors.

In November 2004, UHB held a workshop where governors were presented with the overall strategic aims of the Trust, the targets and the big themes which included the Healthcare Commission’s seven domains.

They broke into work groups to discuss and highlighted their top three priorities. These were then incorporated into the annual plan and we subsequently refined this with them at future meetings.”

Chesterfield Royal Hospital NHS Foundation Trust

“Public governors at Chesterfield Royal Hospital NHS Foundation Trust have already begun to invest their time in the corporation’s plans for capital investment.

With more than £9 million to be spent over the next few years, public governors are bringing a new perspective to numerous project teams. Representing the views of their constituents, governors are helping to shape developments right from the planning stage. Working with directorate teams, estates staff, patients and external contractors they have the opportunity to influence the trust by looking at ideas from the public’s viewpoint.”
And it’s not just lip service. An out-patient project is now in the process of being re-evaluated after governors raised concerns over a potential location.

Alongside capital projects, public governors also have places on specific working groups – including the trust’s research and strategy committee; and they have taken part in special events such as national Think Clean Day, joining staff auditing wards and departments against cleanliness standards.

Barnsley Hospital NHS Foundation Trust

“We have established a range of governors’ sub-groups to enable the governors to focus on key strategic issues and to link with existing groups across the hospital and the wider community. As these sub-groups develop, we envisage that they will provide regular reports to the governing council and identify the issues that need to be referred to the board of directors. The sub-groups will cover the following strategic areas:

- Access and interface to patient services
- Healthy life styles
- Staff/workforce
- The hospital and its environment
- The hospital’s future.”

Leading member focus groups

A number of trusts are now working with governors to convene focus groups of members on key topics. This is enabling governors to develop their understanding of members’ views and providing a means of ‘drilling down’ on key issues to explore how services could be made more responsive and patient-focused.

Cambridge University Hospitals NHS Foundation Trust

“Governors have been given a leadership role in chairing focus groups for members on strategic issues that will have a direct impact on patient care. Five have been held so far on discharge, customer care, hygiene, communication and patient information, and feeding and nutrition. The aim is to produce a set of standards and recommendations for the organisation on each of these topics.”

Membership recruitment and development

The potential to develop the governor role in membership recruitment and development has been identified by many trusts in the first wave. In some places this is already happening, with governors playing an increasingly active role in membership recruitment and taking ownership of the wider membership development strategy.

Homerton University Hospital NHS Foundation Trust

“Our membership development strategy has developed into a strategy and direction owned and led by the governors. A sub-committee of the council of governors – the membership development committee – now leads this work. It meets quarterly and formally reports to the council of governors on membership issues.”

Community outreach

Enabling governors to connect with members and establish an ongoing dialogue is seen by many to be important if governors are to be an effective voice for the community in the affairs of the trust. However, of all the governor roles that are emerging, this is one that has proved to be the most difficult – and the source of greatest frustration for governors themselves.

While many foundation trusts are investing time and effort in developing ways to connect their governors and members, putting a communications infrastructure in place has not been an easy task.

A majority in the first wave are developing a members’ area of the website where people can email governors and a number have circulated governor email addresses in poster form to local GPs, council offices, libraries and advice centres. But with many members lacking email access, it is member newsletters that have become the primary means of raising the profile of governors and encouraging members to make contact.

Different views about the representational role of governors are also emerging. Some trusts are setting up governors’ surgeries to enable members to drop in to discuss issues, while in other organisations this model has been rejected on the basis that it might
lead to governors championing individual cases and getting too involved in operational matters.

An increasing number in the first wave are responding to governors’ desire to feel linked to their electoral constituency by setting up constituency meetings where governors can listen to member concerns and provide feedback on their work and that of the trust as a whole. In contrast, other trusts have felt that it is neither possible nor desirable for governors to represent their individual constituency and have focused instead on bringing governors together with people from across the membership community through regular events.

In recognition of the importance of the governor-member relationship, governors are increasingly establishing sub-groups of their board tasked with overseeing member communications and developing new ways of listening to member views.

Trusts are also having to think through how they fulfil their duty to look beyond their membership to consult and engage the wider public. A number of trusts have begun by trying to align the new governance arrangements with pre-existing patient and public involvement mechanisms. In some cases this has been done by establishing a sub-group of governors to oversee the PPI strategy. Others have encouraged patient governors to attend or chair patient forum meetings and linked public governors with local authority forums to feed the views of patients and the wider electorate into the board of governors.

While changes are expected next year to merge existing patient and public involvement forums so that there is one per PCT, many foundation trusts report that in the meantime, considerable overlap and confusion still exists about the respective roles and responsibilities of forum members and governors.

Royal Devon and Exeter NHS Foundation Trust

“We hold quarterly member meetings in each of our constituency areas attended by our head of membership and mutual development, with governors participating in each event. Each meeting focuses on key themes in the service development strategy to provide a focus for the discussions and to ensure that members can identify areas in which they can genuinely have an input. Governors are taking greater responsibility for these meetings as they become more familiar with their role.”

Guy’s & St Thomas’ NHS Foundation Trust

“One particular success in our efforts to encourage communication between the board of directors, the members’ council and the membership was an open meeting held early in 2005 attended by more than 200 members. We structured the meeting to fall into three segments. Before the meeting proper there was a ‘meet and greet’ session where members of the council met and mingled informally with the membership and were able to talk to them on a one to one or small group basis. This was followed by a session with presentations on subjects known to be of interest to the membership from the responses received to a survey. Two of the presentations on environment and strategy were made by members of the council, each of whom were leading council sub-groups on these issues. The third and final segment of the meeting was an opportunity for members to stay behind and talk informally to board members and council members about the meeting and any other issues. The feedback was overwhelmingly positive.”

University Hospital Birmingham NHS Foundation Trust

“Patient governors are linked into the work of the trust’s four patient councils and in some cases chair the council. The public governors are linked into the local authority constituency committees to enable them to feedback information from the wider electorate.”

Basildon and Thurrock University Hospitals NHS Foundation Trust

“We are developing a members’ area of the website with an ability for members to email governors with their views. Governors are now setting up a sub-group to oversee communication with members, including how public governors communicate with and interact with their constituents.”

Stockport NHS Foundation Trust

“Stockport has established six working sub-groups of the board of governors, including one on communications. This includes a focus on how to develop communications with members, the public and stakeholders, and communication between governors and with their constituents. A second sub-group oversees the PPI strategy, including exploring new ways to seek patient and public views and guiding the development of divisional and trust-wide opinion panels. The other sub-groups focus on working methods, engaging young people, the trust’s travel plan and ‘more than a hospital’ – including fundraising, work with the local strategic partnership and developing other community links.”
Role of staff and stakeholder governors

While the case studies above demonstrate the progress made in fleshing out the governor role, it is increasingly recognised that attention has primarily focused on the new cohort of public and patient governors. Developing the role of staff governors and effectively engaging appointed governors is now rising up the agenda of many trusts.

The ability to give partner organisations a real stake in foundation trusts through their appointment as governors was welcomed at the outset by many aspirant trusts. However, experience of how this has worked in practice is mixed. While a number of trusts report improved relationships and greater partnership working as a result, there is a growing sense that appointed governors have often not participated in the way that foundation trusts envisaged at the outset.

Work is underway in a number of trusts to understand the obstacles to greater engagement and to develop the relationship. A higher rate of churn amongst appointed governors is one problem that has been identified, and some trusts are considering developing rolling induction programmes for appointed governors as a result. Others recognise that more needs to be done to develop a shared understanding about the purpose of the appointed governor role, how they relate to elected governors, and how they can most effectively contribute to the governance of the trust.

Supporting staff governors and clarifying their role is also seen to be a challenge. There is emerging evidence from some trusts of staff governors being used as the conduit to enable staff views to be heard at board level. Others are trying to raise their profile through the staff magazine and by holding drop in sessions. However, many agree that further work is needed to develop a shared understanding about the purpose of the appointed governor role, how they relate to elected governors, and how they can most effectively contribute to the governance of the trust.

The relationship between the boards of governors and directors

Getting the relationship right between the board of directors and board of governors is clearly one of the key challenges of the foundation trust model. But it is not an easy task, not least when governors are finding their feet and boards of directors are themselves growing into new corporate entities responsible for a self-governing organisation.

Through governor induction, development days and ongoing dialogue, first wave trusts are working hard to ensure clarity in respective roles - with boards of governors focusing outwards to represent stakeholder views in the strategic governance of the trust, and boards of directors responsible for the effective running of the business.

Clarifying the different role of governors and non-executives in the new arrangements has also been important, with governors becoming guardians of the community interest and non-executives required to take full responsibility, as corporate board members, for the function and success of the organisation.

A variety of approaches has been taken to establishing two-way communications between the boards. In some foundation trusts, executive directors automatically attend governors meetings, while others attend only by appointment. Equally, while some trusts allow governors to attend board of directors meetings, others keep some or all of their directors meetings closed.

Whatever model is adopted, the challenge clearly is to strive to ensure governors and directors have a shared understanding about the interface between the boards, with transparency and openness about how decisions are made.

Where two bodies are developing and defining their role, there are likely to be tensions as remits are established. This has been true in foundation trusts as they define where the boundary lies between strategic and operational matters and agree what degree of independence governors should have from their director boards. Providing an opportunity for governors and corporate board members to meet informally on a regular basis, as well as formal board to board meetings, is something that a number of trusts have found useful in managing these tensions and building the relationship over time.

In the light of the challenge of making this relationship work, the role of chair is clearly pivotal. While some commentators have queried whether the chair of the board of directors should also chair the board of governors, first wave trusts are clear that a common chair is essential to unite the constituent parts of the new governance model during this first phase of its development.

3 A number of professional bodies have set up forums to support members that have become staff governors. This includes the Nurse Directors Association (www.nda-uk.org) and the Royal College of Midwives and Chartered Society of Physiotherapy (contact sean.osullivan@rcm.org.uk for further information).
Cambridge University Hospitals NHS Foundation Trust

“Establishing the board of governors was the most important governance challenge in becoming a foundation trust. Without careful leadership and management, the ‘two board’ structure could have lost focus and the roles and responsibilities would have collided.

Our approach was to:

- Be clear from the outset that the role of the board of governors was strategic and outward facing
- Provide a focus for the energies of newly appointed governors, particularly through a leadership role in chairing member focus groups
- Be open and accountable. We found that formal governors meetings contained a lot of business and that often the more detailed questions on specific issues could not be fully addressed. Non-executive and executive directors hosted seminars on issues of interest to governors such as PFI, infection control and governance, to support their understanding of key issues and to provide opportunities for engagement and effective scrutiny. At these events it was possible to demonstrate the difference in the two roles, with NEDs discussing their role in chairing trust committees and providing assurance on aspects of business function, and governors contributing the views of constituents and communities in the strategic implications of the issues discussed.
- Provide support through a structured and externally led development programme that focused on developing a shared understanding of the role of governors through case study work and a training needs analysis that identified required skill development opportunities for governors on an individual and collective basis.”

Barnsley Hospital NHS Foundation Trust

“The governing council receives copies of the agenda and minutes of the board of directors’ public meetings, providing them with an opportunity to discuss and comment on all issues debated by the board. The board of directors receives regular feedback from the governing council and takes account of governor’s views on issues such as the future business planning process. Links with the board of directors are being developed by invitation to governing council meetings to discuss specific subjects or policy issues with governors.”

Guy’s & St Thomas’ NHS Foundation Trust

“During the establishment phase, much thought and effort went into building relationships between directors and governors in a way that helped them each to explore and clearly understand their respective roles. Every opportunity was taken in the preparation of written material, presentations and induction to communicate a clear message about the complimentary and collaborative relationship the board of directors sought with the members’ council. Most members of the board attend all meetings of the members’ council and we build opportunities for informal contact between the board and the council into pre and post-meeting programmes.”

Stockport NHS Foundation Trust

“In Stockport there is a good sense of partnership between the board of directors and board of governors with growing clarity over roles and responsibilities. This has been achieved through induction events to which both the board of governors and board of directors were invited and have been followed through by our working methods subgroup where governors are fleshing out what their role will be in practice in relation to strategy, audit and the appointment of directors. Training events have included members of both boards. There is also regular attendance by non executive directors and executive directors at meetings of the board of governors and governors also have an invitation to attend meetings of the board of directors.

In addition, at their meetings the board of governors receive, through the chief executive, a report from the board of directors on the strategic and operational issues affecting the trust. In a similar way, each meeting of the board of directors receives a report following the quarterly meetings of our board of governors.”
Training and support

Establishing an effective induction programme for governors and an ongoing schedule of training is recognised as a vital way of supporting governors as they develop their roles and establish their priorities.

Given the enormous diversity of governors and their different backgrounds and expertise, a number of trusts are conducting a one-to-one training needs analysis and enabling governors to tailor their own programme, as well as providing regular opportunities for the governors to come together and develop their knowledge and skills. Governors are increasingly driving these training programmes by identifying topics where they want further information and support.

Trusts holding regular training events have found that they are also an important opportunity to reflect on governors’ evolving responsibilities and to develop greater clarity and consensus about their role.

University Hospital Birmingham NHS Foundation Trust

“We appointed the Office for Public Management (OPM) to design a programme for the support, induction, training and on-going development of governors. Individual interviews resulted in defining a set of desirable competencies. We responded by designing a complementary programme to run over 12 months, where governors can pick and choose what they require.

This includes:

- Blitz on basics – overview of the trust, NHS, finances and the annual plan
- Development of the governor’s role
- NHS financial regime
- NHS policy, planning and strategy
- Clinical governance
- Performance management
- Regulation
- Research and training
- New hospital
- Clinical seminars.”

Barnsley Hospital NHS Foundation Trust

“Governors have undergone an extensive induction programme, ranging from reading material to hospital tours and a half-day workshop to aid communication between themselves, the membership and staff at the hospital. We have introduced a quarterly programme of awareness/training on key issues. Support to these initiatives is provided by the chairman, the secretary to the board and the governors office.”

Stockport NHS Foundation Trust

“We have organised induction days for governors which have been well attended. The events were externally facilitated and included sessions on the NHS environment, the future strategy for the trust and membership development. We have also organised training events, including:

- a hospital tour
- an introduction to the NHS
- an introduction to strategy and finance
- understanding the media
- clinical services, risk management and patient and public involvement
- medical terms.”

Royal Devon and Exeter NHS Foundation Trust

“Following the first council of governors meeting, Royal Devon and Exeter organised a one day event with their governors to explore their roles and responsibilities and to agree plans for future development days. The four subsequent training days have been spread over a 12 month period and have included the structure and organisation of the NHS and of the trust, a session from each director on their roles and responsibilities, and managing constituency meetings. Other topics have been introduced at the request of governors, such as the role of the chair, governance and links with the PPI Forum. These days have also been helpful in providing a regular forum to discuss and reflect on the governors’ evolving role.”
Emerging issues

Foundation trusts were given little elaboration on the governor’s role beyond the terms of the Act. This freedom has been a source of strength, enabling collaboration with governors to devise innovative ways of engaging them in the trust’s governance.

But it has also been a source of real tension as foundation trusts have grappled with the ambiguities in the wider governance arrangements and struggled to develop a shared understanding of the role.

The lack of clarity and divergence of views about their role amongst governors, as well as between governors and board of directors, has undoubtedly caused real frustration for many governors who have come to the position with high expectations and a commitment to make a difference. This is borne out in a straw poll of 40 governors at a King’s Fund event earlier this year. While 48% of governors present felt there was a clear understanding about their role in their foundation trust, 52% either said there was not or were not sure.4

These case studies demonstrate that while it is still early days, real progress is being made as trusts develop different ways of working with their new boards of governors. No one set of arrangements is right – one size will never fit all given the enormous diversity of foundation trusts. The challenge for each organisation is to enable governors and boards of directors to work effectively together to find locally appropriate solutions and shared agreement on their respective roles.

However, amidst this diversity it is possible to discern some of the ingredients of success. Trusts that have established the most positive relationships have worked collaboratively with governors and developed structured mechanisms for their involvement to harness their energies, enthusiasm and expertise. They have worked hard to open up a dialogue between governors and members to bring the governor’s role as community representative to life. Their boards of directors have demonstrated that they are carefully listening to governors’ views, providing tangible evidence to governors that their efforts are making an impact.

Foundation trusts recognise the need for ongoing investment in the governor role to ensure individuals have the support and information they need to do their job well. Effective induction and training programmes in each trust will remain essential. Active discussions are also now taking place about the possibility of setting up a national forum and network for governors to support them in developing their role, and many governors would clearly welcome this. While the Foundation Trust Network believes it is not appropriate for us to host such a forum given our accountabilities to FT boards of directors, we are committed to working with any emerging arrangements that support the development of foundation trusts.

4 Richard Lewis, Governing Foundation Trusts: a new era for public accountability, King’s Fund, May 2005
The role of the company secretary

The 2003 Act places no requirements on foundation trusts to appoint a company secretary, and this is not a position that has traditionally been a part of the executive team of NHS trusts. However, the new context within which public benefit corporations operate, and the additional governance and compliance requirements linked to foundation status, are leading many trusts to consider the potential benefits of the role.

The Department of Health guidance on foundation trust wider governance suggests that the role of the company secretary might be to:

- ensure the foundation trust complies with relevant legislation and the terms of authorisation issued by the regulator
- establish and review procedures for the sound governance of the trust
- advise both the board of directors and board of governors on developments in governance issues
- ensure meetings of the executive board, board of governors, and any committees are run efficiently and effectively, that they are properly recorded and that directors and governors receive appropriate support and guidance.

In developing the company secretary role, foundation trusts can look to the private sector and learn from their experience of the position and its contribution to upholding high standards of governance. But the model of social ownership on which foundation trusts are based also suggests that much can be learnt from the way the company secretary position has developed in the mutual sector.

The two contributions below — from the Institute of Chartered Secretaries and Administrators (ICSA) and Mutuo — outline these different perspectives on the role of the company secretary and what the key responsibilities of the post holder should be.

Perspectives on the role of the company secretary

Giles Peel, Policy and Development Director, Institute for Chartered Secretaries and Administrators (ICSA)

“Foundation trust status brings with it a number of challenges. The concept of a public benefit corporation is new and, as yet, untested in law. This in turn leads to an absence of case law, which in the situation of a company would provide for much of the precedent for good practice. The structure of the foundation trust is what makes it unique and the uncertainty of this new method of operating provides for much of the current debate on what is best practice.

It must also be remembered that the foundation trust sits within the wider context of the NHS and we can already see a mixture of influences at work. NHS trusts and primary care trusts are evolving all the time and the concept of the need for a company secretary is becoming as strong in these areas as it is in the foundation trusts. Meanwhile the influence of corporate governance from the commercial sector is increasing all the time and much of this will have a direct impact on the evolution of the foundation trust.

What should the company secretary deliver?

The primary output of the company secretary is to introduce a competent structure for organisation and administration, with the aim of reducing complexity. A professional company secretary will deliver this at the highest level in the foundation trust and enable good governance to be cascaded down through the organisation. This includes the management of risk and responsibility with a strong emphasis on appropriate delegation.

The company secretary is, in every sense, the conscience of the trust, sitting alongside but separate from the board. The post should report to the chief executive at minimum and ideally to the chair. This independence of judgement is crucial, and the company secretary must equate in seniority terms with the executive directors with which he or she must interact.

The role brings accounting and legal clarity to the board and is the first port of call for advice on all issues affecting the board. A good company secretary can also manage stakeholder relations and the communications process, a vital necessity in the modern world and one which, if done badly, can have a disastrous effect on corporate image.

5 NHS Foundation Trusts: A guide to developing governance arrangements, Department of Health, September 2004; See also the model job description developed by the Institute of Chartered Secretaries and Administrators at www.icsa.org.uk.
A company secretary is qualified to deliver induction and training of directors and to manage the dialogue between the executive board and governors. All aspects of the conduct of meetings, agendas, procedures, voting and the recording of decisions are all within the company secretary’s remit. The company secretary is the pivot around which the senior direction of the foundation trust will turn. This is especially true of the foundation trust’s relationship with the regulator, Monitor. In all other sectors, the company secretary plays a vital role in the relationship with the regulator, and the same will become true in the foundation trust arena.

In the future, the FT network will expand and the dialogue between company secretaries will develop. An individual holding a professional qualification that enables them to undertake this role will also be able to converse easily with other company secretaries in other sectors, as well as relying on the support of their professional body. This will enable foundation trusts to understand the latest thinking in corporate governance and to apply it in their particular circumstances. The consequences of a foundation trust failing are too serious to contemplate. These organisations have a critical role to play in society. They have reputations to manage, and they interact with a wide variety of stakeholders. They are complex organisations which need to be run in business terms to deliver a medical output. A good company secretary should be at the heart of the process.

Peter Hunt, Director, Mutuo

“The fundamental role of the company secretary in incorporated organisations will be similar, regardless of the legal form adopted by that body. Their basic obligations and duties will not really change. However, the particular types of governance arrangements found in mutual organisations have led to the development of a hybrid role for the secretary in a mutual.

This is due in the main to the existence of democratic structures within the organisation, which require a certain degree of finesse in their management. The level of political skills required is that much greater than in a traditional company given the transparency and complexity of the various stakeholder relationships which are constitutionally based in a mutual.

The secretary is a key, and often pivotal, player in a mutual. In many successful mutuals, a triumvirate of chair, chief executive and secretary work closely together, with the secretary providing particular political support for the chair and intelligence for the chief executive.

In effect, the secretary is the political ‘eyes and ears’ for the chair and CEO. They will typically be the senior manager responsible for operating the constitution and will be expected to have an in-depth understanding of what is really happening at all levels of the organisation’s structure. This means that they will require very specific skills and abilities:

- diplomacy – they need to be trusted by the board and governors alike
- politically astute – able to see and understand a range of motivations
- articulate – advocates of the organisation’s interests

In this role, they will face specific challenges in addition to those faced by all company secretaries and will:

- need to appreciate and manage conflicting interests, often publicly
- be skilled in dispute resolution and mediation
- hold the chair and chief executive (and therefore the trust) together.

Thus in an NHS foundation trust, the secretary will need to develop these skills if they do not already possess them. Unfortunately there is no ready supply of such qualified people and most trusts will need to grow their own. Ultimately, the successful secretary will be an established and trusted lynch-pin for different stakeholders.”
Amongst the first wave foundation trusts, an enormous variety of different approaches to the company secretary position have been adopted. Some trusts have appointed individuals to take on the role on a full-time basis. More commonly, staff have been given company secretary responsibilities in addition to their existing role as Head of Corporate Affairs or Head of Communications. The seniority of the role and reporting arrangements are similarly diverse. Two examples of these different approaches are set out below.

Kate Diggory, Foundation Trust Secretary
Countess of Chester Hospital NHS Foundation Trust

“I was appointed as foundation trust secretary of the Countess of Chester foundation trust in March 2005 following a reorganisation within the executive office. My job description sets out my responsibility to ‘oversee and co-ordinate the corporate governance framework within the trust, ensuring in particular that the council of members and board of directors operate effectively, in accordance with applicable regulations and the highest professional standards’.

I had no previous NHS experience having come from the corporate world where I had held positions as deputy company secretary of a FTSE mid 250 as well as secretary of a private limited company. I have a law degree and was admitted as a fellow of the ICSA in 1980. I work 16 hours per week in this role working alongside a full time board secretary who provides all administrative support to the board of directors and the council of members.

I faced a steep learning curve joining the trust just as it moved into its first annual compliance reporting cycle whilst also battling the complexities of a completely new animal - the foundation trust! I was appointed, I believe, because I could bring to the role my experience of compliance and working within a regulatory framework together with the ability to work with the trust’s stakeholders. The role is evolving as the weeks go by but initially I have been very much involved in working with the council of members and their various sub committees to advise and assist in the implementation of policy and strategy whilst also ensuring that compliance within the constitutional and regulatory framework is maintained. Additionally, my experience of running a shareholder database and preparing for annual general meetings is being used in an overhaul of the trust’s in-house membership database and the preparation for forthcoming elections.

It has been challenging to get to grips with the requirements of the role when there is little precedent to follow. Contact with, and support from, other foundation trust secretaries and membership managers has been invaluable. Reporting to the chief executive, I work closely with both the chief executive and chairman but currently do not have a close involvement in terms of compliance and governance for the board of directors, although this may well be reviewed.”

Alan Lambourne, Foundation Trust Secretary
Derby Hospitals NHS Foundation Trust

“An Associate Member of the Institute of Chartered Secretaries and Administrators since April 1993, I have held the office of company secretary in several organisations, both within industry and financial services. I was also fortunate to hold the position of trust secretary of an acute trust in Lincolnshire between 1994 and 1999, which provided me with a useful initial insight into the NHS.

In November 2004, I was appointed as foundation trust secretary of the Derby Hospitals NHS Foundation Trust. The position is full time, and encompasses not only responsibilities for the administration of the trust board and its committees and corporate governance/compliance, but also secretary to the members’ council, and all aspects of the trust’s membership. I work very closely with the chair and chief executive and other directors of the trust.

Speaking with others in similar roles, it is evident that there are certain core functions for which a trust secretary is responsible, although different trusts often incorporate other responsibilities, reflecting local organisational needs.

At Derby the secretariat function is small, comprising myself as trust secretary, a membership manager and one (part time) clerical/secretarial support.

In terms of responsibilities, the administration of all aspects of the trust board and the members’ council takes up a large proportion of day to day operations, with the remainder involving issues of risk, the assurance framework and general compliance. There have also been various activities which have arisen during the course of the past seven months, including the recruitment of new non-executive directors, members’ council elections, and preparation for the forthcoming annual members meeting in September this year to mention just a few.

As already evidenced, the role will continue to develop, and will be challenging as we move into our second year as a foundation trust.”
**Emerging issues**

Given the diversity of foundation trusts, it is not surprising that no single model for the company secretary position has emerged. However, with many FTs rivalling FTSE 250 companies in size and complexity, there is an increasing recognition of the role's importance and the need to recruit appropriately skilled people to the position, either through external appointment, or by growing existing talent within foundation trusts themselves.

While the role of the company secretary is a new one within foundation trusts, a number of issues are already clear from the experience of the first wave.

Firstly, that irrespective of the decisions organisations have made about where the role sits, a particularly crucial task of the foundation trust company secretary is to act as the lynch-pin that brings together the discussions of the boards, their sub-committees and the trust’s dialogue with members in order to align decision making and ensure coherence between the constituent parts of the governance model.

Secondly, that while there is much to be learnt from the operation of company secretaries in both the private and mutual sectors, there are doubts about the appropriateness of adopting these models wholesale. Foundation trusts, as entirely new legal entities, will have to establish their own model for the role, building on existing good practice in corporate governance in the NHS, mutual and private sectors whilst reflecting on the specific challenges public benefit corporation status presents.

A final theme to emerge is that taking the role of company secretary seriously may require more than devising a job description and finding a suitable candidate. Rather, it may be an opportunity to reflect on the existing roles and responsibilities of the entire corporate board and whether they need to be reshaped or clarified to strengthen the overall governance of the foundation trust.
Conducting governor elections

Establishing a board of governors elected by members is an essential part of the preparation for authorisation as a foundation trust. But how have governor elections been run in practice?

The Health and Social Act requires each foundation trust constitution to make provisions on the conduct of governor elections and requires that any contested elections must be by secret ballot. The Act also enables regulations to be made on the key elements of the process, such as the nomination of candidates, the systems and methods of voting, election supervision and expenses.

In the absence of these regulations, applicant trusts have drawn on a set of ‘model election rules’ issued by the Department of Health which have been incorporated into many trust constitutions. The model rules include a proposed minimum timetable for the key stages in the election process, and the requirement that there must be independent scrutiny of the elections as overseen by a returning officer.

While working within these parameters, applicant trusts have made different decisions about the conduct of their elections. Given a choice of voting system, 19 of the authorised foundation trusts opted for single transferable vote, while 13 chose first past the post. To perform the role of independent scrutineer, a majority of organisations have used Electoral Reform Services, but one trust has used an external consultancy and two have used their local authority to carry out the role.

The Electoral Reform Services perspective on the role of independent scrutiny is set out below, along with three case studies to illustrate the different approaches trusts have taken to their election process.

The role of independent scrutiny: a view from the Electoral Reform Services

“Electoral Reform Services (ERS) is the UK’s leading independent scrutineer of balloting and elections. The foundation trusts we have worked with incorporated the Department of Health’s model rules into their constitution and this document has therefore formed the basis of the election scheme for the governor elections. To date, ERS has handled the board of governor elections for 29 of the 32 established Foundation Trusts.

The duties of the returning officer are extensive and the model rules are very prescriptive regarding the obligations this role entails. The responsibilities involved include:

- Overseeing the publication of the notice of election
- Issue of nomination forms
  On receiving approval to proceed with their application from the Secretary of State, trusts need to invite nominations from their existing members. Trusts, when writing to their members to inform them of this stage, can either enclose a nomination form, or ask them to contact the returning officer who will despatch a form on request.
- Receipt of nominations
  Candidates are invited to provide a summary of why they feel they should be elected; on average this summary is between 100 – 200 words. Some trusts also allow the statement to be accompanied by a passport sized photograph in order to easily identify the nominee.
- Validation of nominations in accordance with the rules
- Statement of candidates
  At the close of nominations, the returning officer must issue a report of all valid candidates. This is publicised throughout the hospital as well as being sent to each nominee. Once the report is issued, candidates have 48 hours to withdraw their nomination.
Uncontested report/notice of poll
Despatch of ballot material
In accordance with the model rules, the election must be conducted as a secret ballot. However, the rules also outline that a signed declaration of identity must be completed and returned with each ballot paper in order for it to be valid. In order to comply with both of these, each ballot pack we issue contains two envelopes. Once the ballot paper is filled in, it is placed in the first envelope (envelope A) and sealed. The declaration is then signed and, along with envelope A, placed in the second envelope (envelope B).

Issuing of duplicates in accordance with the procedures as defined in the constitution
Receipt and validation of ballot packs
On receipt, envelope B is opened and, if completed correctly, the declaration is removed. Envelope A is then opened and the ballot paper removed. By following this procedure the ballot remains secret whilst still fulfilling the required criteria.

Count of ballot papers in accordance with the voting method outlined in the trust’s constitution.

Report
All of this must be done within a set time frame which is also laid out in the model rules.”

Frimley Park Hospital NHS Foundation Trust

“Frimley Park Hospital NHS Foundation Trust was part of Wave 1A, with authorisation given on 1 April 2005. We appointed Electoral Reform Services as the independent scrutineer for our governor elections.

For our election, membership was divided into three constituencies:

- patient/carer – individuals living outside the catchment area who have used the service in the last 5 years
- staff – further sub-divided into five categories (classes) according to directorates
- public – further sub-divided into six categories according to local authority boundaries and hospital admission rates for those areas

The total number of available seats was 26: two patient/carer, five staff and 19 public.

In order to avoid the possibility of all governors being replaced in three years, we implemented a system of rolling elections with the terms of office split into either two or three years. Where possible, terms of office were allocated according to a candidate’s position in the elections, so the highest polling candidate was elected for three years, and the second highest elected for two years. However, as the staff seats were single seats, we requested that ERS draw lots in order to find out how terms of office were staggered for these five class positions.

A nomination pack was sent to every member consisting of a nomination form, a booklet containing the governors’ code of conduct, Nolan principles, NHS core principles and governors exclusion and disqualification criteria, a return envelope, and an explanatory letter. The nomination form invited candidates to submit a structured statement, focusing on why they wanted to carry out the role, what skills they would bring to it and their relationship with the trust.

The total number of words was not to exceed 150. Nominees were also invited to submit a photograph which was circulated with the election material. In accordance with the model rules, each candidate was required to declare whether they were a member of a political party and whether they had any financial (or other) interest in the trust. We also requested that candidates declared any affiliation to health and social care related campaigning or special interest groups. Finally, candidates were obliged to sign a declaration, again in accordance with the model rules, that their candidacy was to the best of their knowledge valid.

As a result of the nomination mailing, a total of 127 valid nominations were received; all but one constituency required elections and no vacancies were left unfilled.

A ballot pack relevant to each constituency was sent to all members in the contested constituencies. The pack consisted of:

- a ballot paper
- a booklet containing election statements and photographs
- an explanatory letter
- a declaration of identity
- an ‘inner’ envelope (for completed declaration of identity)
- a reply paid envelope

These packs were sent to a total of 5,641 members. The election ran for just under three weeks with an overall turnout of 48% - the highest of all Wave 1As.”
University Hospital Birmingham NHS Foundation Trust

“University Hospital Birmingham NHS Foundation Trust contacted each member by letter, inviting them to consider standing as a governor in the appropriate categories. Nearly 80 people put themselves forward to be governors and contested elections were held for 24 governor seats.

Thirty two patients were nominated for the six patient seats and contested elections were held in all but one of the public seats. Each member of the foundation trust was eligible to vote for candidates in their constituency. In the case of patients, each person who stood needed to be nominated by another person from that category. In the case of the public constituents, each person who wished to stand needed to be nominated by another public member from that constituency group.

Those who stood were able to spend up to £100 on election expenses. Each candidate nomination was supported by a 200 word election address. We edited and printed these and sent them out to the appropriate electorate as those who stood were unable to have a list of the electorate due to Data Protection Act restrictions.

We employ an outside company to maintain and manage our membership database, and given their experience of dealing with PLCs and shareholder mailings, we decided to use them to oversee the election process.”

South Tyneside NHS Foundation Trust

“South Tyneside NHS Foundation Trust was part of Wave 1A, authorised on 1 January 2005. For our governor elections, we used our local authority electoral office, demonstrating our commitment to local partnership working.

For the purpose of the election, the membership was divided into two constituencies with a total of 16 elected governors:

- Public – subdivided into a further six classes based around ward boundaries and local authority Community Area Forums, each with two governor representatives;
- Staff – sub divided into two groups: clinical and non-clinical staff, both having two governor representatives.

South Tyneside adhered to the model election rules issued by the Department of Health. In addition, attendance at a governor awareness session was mandatory for prospective nominees if nominations were to be valid. Almost 100 people attended the awareness sessions.

The electoral office handled the whole process, from agreeing timescales and deadlines, to the drafting and printing of all election material. They also provided an invaluable service in validating public registers and providing a personal service to nominees, checking nomination forms were correctly completed and valid at the point of submission.

In total, 51 nominations were received and all constituencies held an election. Turnout out at the elections was excellent with an average turnout amongst public members of 59% and 34% of staff.”

Liverpool Women’s NHS Foundation Trust

“Following its first membership council election, Liverpool Women’s NHS Foundation Trust was keen to assess the attitudes of its public membership towards its democratic processes. We commissioned a sample survey of current members designed to inform the trust’s strategy for engaging its membership in the future.

The research provided valuable information on how to encourage more members to participate in future elections. They included the need to raise awareness of the election process, to give people enough time to vote, quick feedback and a clear exposition of the views of candidates. On a positive note, the research concluded that far from being apathetic and disinterested, the overwhelming proportion of members would be keen to participate given the implementation of some straightforward practical measures.”

Following the first set of governor elections, a number of trusts have analysed the results to look at the profile of members voting and to understand why some chose not to vote. This information has been used to inform the conduct of future elections and to boost voter turnout.
Emerging issues

A number of emerging themes can be discerned from the elections conducted by first wave trusts.

For the first 20 foundation trusts to be authorised, over 185,000 people were members at the time of the elections for the boards of governors, and the overall turnout at the elections was 36% – a figure that compares well with voting rates in local elections, particularly when you consider the newness of foundation trusts and the efforts they have had to expend to establish their profile in the local community.

However, moving beyond the headline figures does reveal significant variations, with a highest overall turnout of 67% and a lowest of 11% for the first cohort of 20 trusts. Analysing the turnout figures by constituency also reveals a similarly diverse picture:

- 53% for the overall public constituency turnout [70% highest/31% lowest]
- 27% for the overall patient constituency turnout [85% highest/16% lowest]
- 26% for the overall staff constituency turnout [64% highest/16% lowest]

The ability of the Royal Marsden to achieve the highest turnout (67%) with the smallest number of members (1,122) underlines the points already made about the need to balance a focus on breadth of membership with the importance of fostering genuine membership engagement. As Richard Lewis points out in a recent King’s Fund paper, “arguably, a small but highly active membership is just as capable of articulating patient, staff and public views to influence the management of foundation trusts.”

The significantly lower staff turnout compared to the general public also underlines points already made about the need to actively engage staff and to demonstrate the practical ways in which the new wider governance arrangements can give them a greater say. This is particularly important where trusts have pursued an opt-out policy for staff. Analysis of the first 20 foundation trusts by the Nuffield Trust found, predictably, that while “the opt-in model produced small memberships but a relatively high rate of participation in the elections (in the range of 40% to 70%), the opt-out model produced large memberships but lower rates of participation (in the range of 16% to 60% with most of them at the lower end of the distribution).”

Voter turnout is likely to remain a key litmus test of whether members feel engaged in their foundation trust. Future voting trends will be closely tracked for evidence of whether trusts are succeeding in sustaining and increasing member interest and involvement in their work. Ensuring the electoral process is managed effectively and learning from voters about how it could be improved will remain a vital part of the process of building relationships with members over time.

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Members and governors

what Monitor will be looking for

Stephen Hay, Chief Operating Officer

We have a clear idea of what a successful NHS foundation trust will look like. It will:

- deliver high quality healthcare, meeting and exceeding national health targets and standards
- be financially stable, beginning to generate surpluses and borrow to invest in improved patient services
- be actively engaged with its community through its members and governors.

In establishing strong relations with governors and members Monitor’s view is that, in the short term, close regulatory direction is not likely to result in success.

It is undoubtedly an important area; that is why membership is the only governance area where we do not rely on FTs to self-certify. But we recognise that these aspects of governance are new and that we are all still learning about how accountability to members and governors can be made to work most effectively.

We have therefore shaped our regulatory approach in this initial phase in a relatively light fashion.

We ask for an annual membership report detailing plans for the future and expected growth in membership numbers. We are scrutinising these reports to assess whether the requirement to continue to take steps to achieve representative membership is met. FTs will need to demonstrate that they understand the social and demographic profile of their constituencies and membership, and that the membership strategy reflects this profile.

We will not be making judgements as to the pros and cons of membership strategies because we do not have a fixed view as to what the “right” membership strategy is. Indeed we are entirely comfortable with the rationale that membership strategies should be different between different organisations. Some foundation trusts will want to set stretching targets for membership growth, in others it will be appropriate to focus on high quality engagement with a smaller group of members.

Likewise we are watching with interest how the role of governors develops and how FTs respond to this new form of accountability.

Over time we will undoubtedly develop firm views on how best to develop strong and effective relationships with members and governors, and that may allow us to start benchmarking the performance of individual FTs, if we felt it appropriate to do so.

For the present our focus is on encouraging development of best practice, which is why we welcome this publication and will continue to work with the FT Network in this area.
How wider governance is helping foundation trusts

Foundation trusts are organisations in transition. But the case studies in this guide provide real evidence that their wider governance arrangements, initially dismissed as an afterthought, are becoming an integral and vital part of the foundation trust model.

Whilst recognising that there is much more work to be done, many first wave foundation trusts are clear about the emerging benefits of their wider governance model, as well as the potential for it to deliver further improvements over the longer term. This includes:

- enhanced transparency and openness in the way the trust is governed and how it communicates with the local community
- the board of governors as a forum for fresh ideas and innovation through bringing an outside, lay perspective to the work of the trust
- a register of individuals who are interested in the trust and can be consulted on existing services and new initiatives to ensure they are more responsive to patient needs
- a means of raising awareness amongst the local community about the benefits and implications of service change
- a new set of ambassadors for the trust in the wider community, to promote the trust’s services and feed back community views
- improved health literacy by informing members and governors about health issues and enabling them to educate friends and relatives
- increased understanding and greater partnership working with stakeholder organisations

**Queen Victoria Hospital NHS Foundation Trust**

“We have gained a membership committed to the work of the QVH and who understand that it is a community and a specialist hospital. It has given a feel of the wider community being involved in our work. It has given us the chance to explain more about the work our staff do and to increase understanding of the NHS. Finally, it has also provided us with the advantage of 13,000 committed supporters and vocal ambassadors.”

**Stockport NHS Foundation Trust**

“We believe that the board of governors and wider membership support the meaningful involvement of local people, patients and our key partners in influencing our priority setting, planning and decision making. This wider governance model has been used:

- to raise the awareness of our membership and local community about the implications of service change, including seeking views on plans for a new cardiology and surgical unit for which building has now commenced
- as a source of active support for volunteers and patient and public involvement initiatives
- to engage local people in our plans to be ‘more than a hospital’, i.e. investing in our local communities of Stockport and the High Peak
- to raise awareness of the choice initiative and to encourage local people to support their local hospital
- to encourage governors and members to influence clinical networks.”
Cambridge University Hospitals NHS Foundation Trust

“Membership brings enormous value to the foundation trust. The membership:

- is a register of individuals who are interested in the Trust and are therefore generally willing to be consulted on numerous issues
- provides the Trust with a ready resource for public and patient consultation exercises (although not an exclusive one)
- elect from their own number governors who provide the Trust with an outside, lay perspective on issues of broad strategy and planning – providing a forum for fresh ideas and innovation
- adds value to the public image of the Trust – informing members about important topics as well as dispelling myths empowers them to educate friends and relatives about health related subjects and issues
- enhances the transparency of the Trust
- promotes the concept of the Trust as a ‘good neighbour.’”

Basildon and Thurrock University Hospitals NHS Foundation Trust

“The members’ council is adding real value to the foundation trust’s governance structure. A majority are now holding informal meetings every six weeks as well as meeting regularly with executive directors and attending board of directors meetings. They are also keen to link with other lay reps in partner NHS and other organisations. This, together with the interaction with appointed governors from local authorities, the PCTs, CVS and local education providers, is leading to increased understanding and knowledge, greater partnership working and positive and friendly relationships at all levels within a large number of local organisations.”

This is clearly only the first staging post in the development of the foundation trust movement. But these early successes mark the beginning of the shift from a centrally managed NHS to one which must forge new relationships with local stakeholders to improve services to patients and the quality of life of local people.

The Foundation Trust Network is committed to charting the challenges and achievements of this journey, and to share emerging learning, not just with those preparing for foundation status, but the rest of the NHS. We hope the FTN member case studies in this guide will be part of this process.