MEMBERSHIP GOVERNANCE IN NHS FOUNDATION TRUSTS:

A REVIEW FOR THE DEPARTMENT OF HEALTH

CHRIS HAM, HEALTH SERVICES MANAGEMENT CENTRE, UNIVERSITY OF BIRMINGHAM

AND

PETER HUNT, MUTUO

MARCH 2008.

Contents

1. Executive Summary

NHS Foundation Trusts were created under the Health and Social Care (Community Health and Standards) Act 2003. They are a new type of NHS organisation, public benefit corporations, with members drawn from the communities they serve. Members elect a board of governors which also include stakeholder representatives from primary care trusts, local authorities, universities and other organsiations. The board of governors works with the board of directors in ensuring effective oversight of the work of NHS Foundation Trusts and in advising on their long term direction.

This report focuses on membership governance in five established NHS Foundation Trusts and one NHS Trust that was applying to become an NHS Foundation Trust at the time of our research. It is based on analysis of papers provided by these organisations and interviews with a cross section of people in each, typically including the chair, chief executive, company secretary and a selection of governors. In addition, information was obtained from Monitor, the Foundation Trust Network and the Department of Health. The main focus of the report is the experience of creating a membership, establishing a board of governors, and deciding how best to use members and governors.

The evidence we have gathered suggests that the hybrid governance model adopted for NHS Foundation Trusts is working increasingly effectively. As the model has developed, there is greater clarity about the role of the board of governors and how the knowledge and skills of governors can be used to best advantage. The statutory powers of governors have helped to ensure that they are taken seriously and are not treated as rubber stamps.

There is less clarity on the role of the membership community and the most effective way of governors relating to members. NHS Foundation Trusts are communicating with members in various ways but recognise that more needs to be done to become membership organisations. The experience of the mutual sector needs to be drawn on to enable NHS Foundation Trusts to make further progress in this area.

The Trust chair is the lynchpin in the governance arrangements of NHS Foundation Trusts. The chair has to be able to lead the work of the organisation through the board of directors and relate to the membership through the board of governors. Each role needs a different style, requiring chairs to be adaptable in the way they function. While there may be an argument for the role of chair to be split, we do not believe this is the best way forward.

The company secretary has a key role in governance and with his or her staff is usually the main point of contact for governors and members. Realising the full potential of NHS Foundation Trusts is likely to mean strengthening the role of the secretariat. NHS Foundation Trusts need to consider how they continue to invest in and develop this function.

Members and governors are already making a difference to how NHS Foundation Trusts carry out their responsibilities. This is most evident in relationships with patients and the public, and the increased awareness of managers and clinicians of the views of service users. Thought needs to be given to whether NHS Foundation

Trusts should be expected to make the same use of patient and public involvement mechanisms as other NHS organisations, or should relate to patients and the public mainly through members and governors.

2. The Origins of NHS Foundation Trusts

NHS Foundation Trusts were established under the Health and Social Care (Community Health and Standards) Act 2003. They are a new type of NHS organisation, public benefit corporations, with a primary purpose of providing NHS services to NHS patients.

NHS Foundation Trusts have members who are drawn from the communities they serve. Members include local residents, patients, carers and staff who register their interest with the NHS Foundation Trust. As well as having a stronger relationship with local communities than NHS Trusts, NHS Foundation Trusts have a number of freedoms e.g. to retain financial surpluses and to borrow money from public and private sources within the limits of the prudential borrowing code.

Unlike NHS trusts, NHS Foundation Trusts are not under the direct control of central government. The activities of NHS Foundation Trusts are overseen by an independent regulator, Monitor, whose job is to ensure that they comply with the terms of their authorisation.

NHS Foundation Trusts were created as part of a policy of devolving power within the NHS. In pursuing this policy, the Government was concerned to establish stronger connections between NHS services and local communities, hence the choice of the public benefit corporation model, and the emphasis placed on the role of members in the work of NHS Foundation Trusts.

The mutual tradition

NHS Foundation Trusts and their governance are based on experience in other sectors as the following extracts from early government guidance shows:

'The new governance arrangements for NHS Foundation Trusts have been modelled on co-operative societies and mutual organisations. These combine community ownership with accountability' (DH, 2002, 10)

'NHS Foundation Trusts will herald a new form of social ownership where health services are owned by and accountable to local people rather than central Government. In this way, much stronger connections will be established between providers of NHS services and their stakeholder communities…In a similar way to becoming a member of a co-operative society or mutual organisation, the members of an NHS Foundation Trust will become its owners, taking on responsibility for their local hospitals from national Government' (DH, 2002, 15)

'The members of an NHS Foundation Trust will, collectively, be its legal owners. This is a real and not a paper exercise in social ownership. As such the rights of membership will therefore confer some limited but real legal responsibilities. The registered members will be the 'guarantors' of an NHS Foundation Trust. This means that if the organisation became insolvent and had to be wound up its members would each be liable under the terms of the NHS Foundation Trust's constitution to pay a nominal sum (£1) towards any outstanding liabilities' (DH, 2002, 17-18).

Although the government did not proceed to require members to contribute towards the liabilities of an NHS Foundation Trust in this way, these quotations provide a clear indication of the thinking that lay behind the policy.

As they illustrate, the aim was to mark a radical break with the past by transferring ownership of NHS providers to local communities, drawing on experience in co-operative societies and mutual organisations. To this extent, NHS Foundation Trusts were an example of the government's interest in creating a bigger role for social enterprises in public services, alongside the policy of encouraging investor owned companies to become more closely involved in providing services to NHS patients.

Governance arrangements

Corporate governance is the system and process used to ensure proper corporate standards, probity and openness in the conduct of business. The basic principles in good corporate governance systems include transparency, accountability, fairness and responsibility, which are put into practice by a combination of statutory rules and self-regulation in corporate 'codes of best practice'. The main focus of this level of governance is trust boards - its executives and non-executives - and the standards they adopt in managing the business

In addition, NHS Foundation Trusts, like other mutuals, are accountable to their members. By virtue of their ownership, mutuals face a number of specific corporate governance and accountability issues. How this aspect of governance is working is the focus of this report, and for clarity, we will use the term 'membership governance' to describe it. In this context, membership governance concerns the means by which members hold the organisation to account.

The independent regulator, Monitor, has sought to drive the governance standards through trust boards. Less attention has been given to membership governance to date but in many ways this is just important in enabling NHS Trusts to make the transition from state owned public organisations to social businesses. Getting membership governance right will not happen simply through the adoption of a new constitution but depends on NHS Foundation Trusts learning to become membership organisations and adopting new behaviours and relationships in the process.

In more detail, the governance arrangements for NHS Foundation Trusts have three main elements (DH, 2004):

- a **membership community** comprising local people, patients and staff, including patients and carers living outside the area if the Trust chooses to make them eligible for membership

- a **board of governors** made up of members elected from the membership community as well as people appointed by primary care trusts and local authorities. NHS Foundation Trusts with a medical or dental school are also required to have at least one University governor. There may also be other partnership governors to represent local partner organisations. Governors elected by public and patient constituencies must be in a majority

- a **board of directors** made up of a Chair and non-executive directors appointed by the governors, a chief executive appointed by the non-executive directors with the approval of the governors, and executive directors appointed by the chief executive and non-executive directors

The Chair of the board of directors also serves as the Chair of the board of governors.

Within this framework, each NHS Foundation Trust is able to determine its own governance arrangements, and the detail of these arrangements varies. As an example, the number of people serving on the board of governors varies between NHS Foundation Trusts, as does the number of staff governors and partnership governors (Day and Klein, 2005).

The board of governors

Government guidance has emphasised that the board of governors is responsible for representing the interests of the local community in the management and stewardship of the NHS Foundation Trust, and for sharing information about key decisions with other NHS Foundation Trust members. While the board is charged with ensuring that the Trust operates in a way that fits with its statement of purpose and complies with the terms of its authorisation, it is **not** responsible for the day to day management of the organisation.

As described by DH (2002), the main duties and responsibilities of the board of governors are:

- establishing mechanisms for consulting the members or partner organisations they represent;

- holding at least one meeting a year that is open to all members to approve the annual report and accounts and the appointment of an auditor;

- meeting on no less than two other occasions a year, when the main business is to advise the board of directors on the Trust's forward plans; and

- as required, to appoint the Chair and non-executive directors, approve the appointment of the chief executive by the Chair and non-executive directors; and ratify appointment by the chief executive of executive directors

Later guidance identified three types of role for the board:

- **advisory** – providing a steer on how the NHS Foundation Trust can carry out its business in ways consistent with the needs of the members of the wider community

- **guardianship** – acting as guardians to ensure that the NHS Foundation Trust operates in a way that fits with its statement of purpose and complies with its authorisation

- **strategic** – advising on the longer term direction for the NHS Foundation Trust.

In relation to the last of these roles, the guidance emphasises that there is potential for confusion between the board of governors and the board of directors, and that this needs to be discussed to avoid disrupting the effective working of the governance arrangements.

The membership

Government guidance has also emphasised the need for the board to represent the socio-economic mix of the local community, with the elected governors being representative of their membership. In addition, the guidance states:

'the board of governors…need to be skilled and practised in stakeholder engagement, consultation and participation. If, once appointed or elected, governors do not see it as a responsibility to consult the constituency that elected them then they will lose touch with the aspirations and needs of the very people they claim to represent' (DH, 2004, Section 4).

The benefits of having members of NHS Foundation Trusts as set out in guidance include:

- people tend to get personal satisfaction and skills from engaging in public services and mutual organisations

- participation in an organisation can bring benefits to the organisation and its stakeholders

- staff feel that they have a productive personal stake in the organisation by being involved

In creating a membership, NHS Foundation Trusts were advised to make use of existing mechanisms for engaging with patients and the public, and to utilise a range of mechanisms, such as meetings, and electronic or telephone techniques. In addition, they were urged to find novel ways of reaching groups who might not naturally become engaged with the NHS, including children and young people, and people from black and minority ethnic communities. Having established a membership, the importance of continuing the dialogue was emphasised, through the provision of information and regular communications of different kinds.

Foundation trusts in action

The most comprehensive review of the early experiences of NHS Foundation Trusts was undertaken by the Healthcare Commission (2005).

The number of governors in the NHS Foundation Trusts studied ranged from 18 to 39 with an average of 33.

It was found that large groups allowed wider representation of the local community and access to a broader range of skills, but they could slow the process of decision making and required more support. In these trusts, there was an average of five staff governors.

The Healthcare Commission found that many of the elections for governors were competitive and there was more than one candidate for 85% of the posts of governor drawn from the public and 73% of the posts of governor drawn from patients. However, the turnout rate varied widely between NHS Foundation Trusts, from 19% to 67% for the posts of governor drawn from the public, and 31% to 70% for the post of governor drawn from patients. Election turnout for staff governors was the lowest among all the constituencies; these elections were also those where it was most likely that only one candidate would stand.

Governors reported that they needed to meet more frequently than the statutory minimum of three meetings a year in order to develop as a group and keep up to date on issues. One of the issues noted by the Healthcare Commission was the additional cost of providing administrative support for members and governors. This cost arose through the need to appoint additional staff to manage and develop the membership, the use of commercial companies to manage databases of membership, and the costs of communicating with members.

Recognising that it was too early to assess the impact of governance arrangements, the Commission concluded:

- Trusts had initially drawn in between 1,000 and 16,000 members of the public and patients

- Most had increased membership, by an average of 37%, by the end of 2004

- Membership had helped to increase attendance of the public at annual general meetings and provided a resource to contribute to reviews of services

- Leadership, accountability and responsibilities were clearer at the level of the board, providing more focus on financial risks, strategic issues and working in partnership

However, the review also found that:

- few NHS Foundation Trusts took specific action to involve groups of the population who are traditionally poorly represented

- the roles of governors were unclear beyond their statutory duties; opportunities for training, support and development were variable, as were the perceived legitimacy and influence of the governors

- the dual role of the Chair of the board and the governors could cause conflict

- there was an overlap of functions between the board of governors and public and patient involvement forums, with both seeking to represent the public and

patients, which caused confusion; there was also overlap with overview and scrutiny committees and concerns about excessive local scrutiny

- there was low engagement of staff, as initiatives such as Agenda for Change were considered to have more effect on their working lives

A more limited study supported by the Nuffield Trust of the first 20 NHS Foundation Trusts to be established emphasised the diversity of governance arrangements that had been established (Day and Klein, 2005). Diversity reflected the freedom allowed to NHS Foundation Trusts to determine their own arrangements within the broad framework laid down by the government. Examples of diversity included whether trusts had separate constituencies for patients and the public; whether elections were organised around geographical constituencies or not; and the type of voting system used e.g. single transferable vote or first past the post.

This study echoed many of the findings in the Healthcare Commission's review in relation to elections to the board of governors and the size and composition of boards. In addition, based on the limited evidence available, Day and Klein noted that women appeared to be under represented on boards, and that a high proportion of elected governors were retired.

As far as the role of governors was concerned, they found that boards had influence rather than power, with chairs and chief executives controlling the flow of information to governors and controlling the agenda. The other point of note in this study was the observation that Monitor had focused almost exclusively on financial affairs and management capacity, and had paid little attention to membership governance issues.

In so far as Monitor has explored membership governance issues, its interest has mainly related to collecting and publishing data on the membership of NHS Foundation Trusts and elections. For example, a report published in 2004 noted that the overall turnout in elections was 36%. Turnout ranged from 26% in the staff constituency through 27% in the patient constituency to 53% in the public constituency (Monitor, 2004). The report also noted that the number of members of NHS Foundation Trusts had continued to increase, reaching over 250,000 by August 2004.

A report by the King's Fund (Lewis, 2005) drew on Monitor's analysis to offer an early snapshot of governance arrangements in NHS Foundation Trusts. The report echoed the findings of the Healthcare Commission in respect of the role of governors, and particularly lack of clarity about their role. In addition, a straw poll of governors conducted by the Fund found that over 40% of governors were not sure they had made a difference to the running of their trusts, and almost half considered that they did not have an effective route to communicate with the members who had elected them. On the other hand, 70% reported that they were confident that they would make a difference to the running of their trusts in future.

To bring the story up to date, by February 2008 there were 88 NHS Foundation Trusts with almost 1 million members and over 1000 governors. A report published

by the NHS Foundation Trust Network summarised the experience and contribution of some of these governors (Foundation Trust Network, 2007).

3. **Our findings**

Against this background, in June 2007 we were commissioned by the Department of Health to undertake a review of progress made in a number of NHS Foundation Trusts. The aim of the review was to gain an understanding of how membership governance arrangements were working in practice in five existing NHS Foundation Trusts and one applicant NHS Foundation Trust. The NHS Foundation Trusts included in the review were selected in discussion with the Department with the aim of ensuring that they covered different parts of the country, a range of services, and organisations that achieved NHS Foundation Trust status in different waves.

The main focus of the review was governance arrangements and specifically the experience of the organisations involved in creating a membership, establishing a board of governors, and deciding how best to use the members and governors. In the process of exploring these issues, the review examined a number of related questions, including the relationship between the board of governors and the board of directors, the role of the chair, the role of the company secretary, and the training and support provided for members and governors. In addition, the review explored the relationship between the role of members and governors on the one hand, and alternative forms of patient and public involvement on the other.

In commissioning the review, the Department of Health was interested to understand what could be done to strengthen governance arrangements within the existing statutory framework. In the conclusion to this report we identify a range of options that might be explored further with this in mind.

The review was undertaken by Chris Ham of the Health Services Management Centre at the University of Birmingham and Peter Hunt of Mutuo. Site visits were made to six NHS organisations to gather information for this report. The organisations were:

Birmingham Women's Health Care NHS Trust

Bradford Teaching Hospitals NHS Foundation Trust

Derby Hospitals NHS Foundation Trust

Royal Devon and Exeter NHS Foundation Trust

South Essex Partnership NHS Foundation Trust

University College London Hospital NHS Foundation Trust

On each visit, interviews were undertaken with a cross section of people, typically including the chair, chief executive, company secretary, and a number of governors drawn from different groups. The interview schedule used during these visits is appended to this report. In addition, information was gathered from Monitor, the Foundation Trust Network, and the Department of Health. The NHS organisations visited were given the opportunity to comment on notes made during the interviews and to provide additional information relevant to the review.

It is important to emphasise that the findings that follow are drawn from a small number of organisations at a particular time in their development (all site visits took place between September and November 2007). They are therefore not intended to offer a comprehensive or in-depth assessment of governance arrangements in NHS Foundation Trusts. The findings should be read alongside other relevant work, such as the survey Monitor has undertaken of NHS Foundation Trust governors (the results of which we have not seen), surveys carried out by the Foundation Trust Network, and the longer term research project being conducted by the London School of Hygiene and Tropical Medicine.

In exploring the questions contained in our interview schedule, a number of themes recurred in the interviews we undertook, echoing earlier work summarised above. We have used these themes as a way of organising and presenting our findings. In so doing, we have included examples of what the organisations we visited have been doing to illustrate the evolution of governance arrangements.

Governors

The following table provides data on the size and composition of the board of governors in the organisations we studied.

Trust	Public/Patient	Staff	Stakeholder	Total
Birmingham Women's	14	5	7	26
Bradford	12	4	5	21
Derby	18	7	7	32
RDE	19	5	7	31
South Essex	28	5	17	50
UCLH	17	5	11	33

As the table shows, the size of the board varies from 21 governors in Bradford to 50 in South Essex. The most common arrangement is for the board to comprise around 30 governors with public and patient governors constituting a majority. Staff and stakeholder governors make up the balance and usually there are more stakeholder governors than staff governors.

Bradford is the only organisation in our study that has changed the size of the board, having reduced the number of governors from 33 to 21 at the time the NHS was reorganised (through the reduction in the number of PCTs) in 2005. This change was motivated by a feeling that a board comprising 33 governors was too big to function efficiently. Early experience with a smaller board was reported to have confirmed the benefits of making this switch.

The role of the board of governors in these organisations followed closely the guidance issued by the Department of Health and summarised above. In Bradford, the chair and chief executive described this role as having three elements:

- **statutory functions**, on which we comment more below

- **roles in which governors lead** within the Trust, an example being membership development, and

- **roles in which governors participate** e.g. through involvement in Trust committees and working groups.

On a number of visits we heard of difficulties in the initial stages of NHS Foundation Trust development in ensuring that governors understood their role, and how this related to the board of directors (see below). In Derby, the chair took a lead in seeking to clarify these issues by writing a paper that was discussed and agreed with the governors. The table that follows shows the outcome of this work. Here and elsewhere, there is a view that the novel (for the NHS) governance arrangements of NHS Foundation Trusts take 2-3 years to bed in.

The Role of Governors in Derby Hospitals NHS Foundation Trust

ROLE	EVIDENCE
Ambassadorial	
Represent the interest of members and other organisations in the health community.	Constituency meetings
Feed back information about the Trust its vision and performance to members (constituencies) and the other stakeholders that either elected or appointed them.	Newsletters (Constituencies) Members' Lectures Programme
Ensure that the interests/needs of the members and the public are taken into consideration in the Trust's strategic planning.	Interactions – members' magazine (quarterly)
Constitutional/Statutory	
Select and appoints Chair of Trust and Non-Executive Directors and set remuneration.	Appointment and Remuneration Committee
Approve appointment of Chief Executive.	Council of Governors
Select and appoint External Auditors.	External Auditors Appointment Committee (Joint membership – 3CG members and 3 members of Financial & Risk Audit Committee (Trust Board)
Receive and consider Annual Report and Accounts and External Auditors' Reports.	Council of Governors
Review role and composition of Council of Governors.	Council of Governors - Development Days
Review and develop Membership Development Strategy and Communications Strategy.	
Develop and promote membership of the Trust.	Membership Group and full Council
Act in the best interest of the Trust and adhere to its values and code of conduct.	

ROLE	EVIDENCE
Guardianship	Membership of various committees and groups:
Ensure that the Trust operates in a way that fits in with its statement of purpose and complies with its terms of authorisation.	**Council of Governors:** Annual Plan Working Group **(5)** Appointment & Remuneration Committee **(4)** External Auditors Appointment Committee (Joint membership GC & FRAC) **(3)** Membership Group **(9)**
Monitor performance against the Trust's Service Development Strategy and other targets	**Trust Board:** Charitable Funds Committee **(2)** Clinical Effectiveness Committee **(1)** Design, Arts & Wayfinding **(2)**
	Trust: A&E Forum **(4)** Celebrating Success **(5)** Child & Friendly Feedback Group **(1)** Celebrating Success **(5)** Child & Family Feedback **(1)** Emergency Care Network Board **(3)** Essence of Care Group **(1)** Health Care Standards Group **(6)** NSF Long Term (Neurological) Conditions **(1)** NSF for Older People **(1)** Patient Environment Assessment Team **(1)** Patient Experience Group **(1)** Planned Care Strategy Group **(1)** Service Improvement Modernisation Group **(1)** Staff Forum Action Team (staff reps **(1)**
	University of Nottingham: Medical Selection Committee (Panel)
Advisory	
Support the Board of Directors in terms of strategic guidance by advising and giving feedback/recommendations on:	Through meetings of Council of Governors and membership of committees and groups. Also Joint Meetings.
Trust's Strategic Objectives/Service Development Plans 2004/09	
Annual Plan	Annual Plan Working Group
Healthcare Commission : Annual Health Check	Health Care Standards Working Group

We heard on more than one occasion the view that because of their numbers and role, the governors did not constitute a board as commonly understood. In recognition of this, various terms were used to describe the governors collectively, with Members Council and Council of Governors being examples.

Most governors appear to be playing an active part in NHS Foundation Trusts, although the attendance of stakeholder governors at meetings often lags behind that

of other types of governor. This seems to depend largely on the attitude taken by trusts to poor attendance. At Royal Devon and Exeter, initial problems with poor stakeholder attendance have subsequently been tackled by their 'discipline committee,' a self-regulatory sub-group with the ultimate power of expulsion.

Much of the early attention has necessarily been concentrated on ensuring that public governors have been supported in their role, and this has meant that the staff governor role has remained relatively undeveloped. As Trusts continue to evolve, attention should be given to the particular needs of different categories of governor. For staff governors, there is significant potential for expanding their role in the work of the Trust and linking it with overall human resources strategies.

Boards of governors meet with varying degrees of frequency, and usually more often than the minimum requirement laid down by statute. In Bradford, for example, the board met every two months following the financial difficulties that arose in 2004, and the changes to top management that followed. Now that the NHS Foundation Trust has overcome these difficulties, the frequency of meetings will be reduced to quarterly with an AGM.

South Essex is an example of a particularly active board of governors with meetings held monthly and governors also involved in various sub-committees. The other organisations visited also make use of sub-committees, both in relation to the statutory powers of governors, and in relation to membership development and related issues. Some sub-committees are made up of governors only, while others involve governors and others in their membership (see the box on Derby above for an example).

A varied picture emerged in how governors are using their statutory powers. In some organisations, governors appeared to be playing a constructive role in appointing the chair and non-executive directors, approving the appointment of the chief executive, and agreeing the remuneration of the chair and non-executives. In others, difficulties were reported, with governors expressing concern at the way in which they had been involved in these issues.

Statutory Powers of Governors

- To appoint or remove the Chair and other non-executive Directors

- To decide the remuneration and allowances, and the other terms and conditions of office, of the non-executive Directors

- To approve an appointment (by the non-executive Directors) of the chief executive

- To appoint or remove the Foundation Trust's financial auditor

- To be presented with the annual accounts, any report of the financial auditor on them and the annual report

- To provide their views to the Board of Directors when it is preparing the document containing information about the Foundation Trust's forward planning

As an example, in one NHS Foundation Trust the governors involved in non-executive appointments were critical of their exclusion from the short listing process, leading to a feeling that they were being presented with a fait accompli. Another area of difficulty concerned remuneration. Governors in some organisations had decided not to increase remuneration for the chair and non-executives in line with other NHS Foundation Trusts and this has been a source of friction between the board of governors and the board of directors.

Having made these points, it is clear that the existence of these statutory powers means that governors have to be taken seriously. This is important given a view sometimes expressed that governors sit uneasily between the corporate leadership role of the board of directors and the representative role of the membership. In the words of governors we interviewed, statutory powers mean that governors are not simply a 'rubber stamp'.

The influence that governors are able to exert over appointments and remuneration, as well as their role in appointing the auditors, requires the Trust chair and chief executive in particular to work to ensure that the governors are involved appropriately in the work of their organisations, and can see that their contribution is making a difference. We heard examples of how Trusts had changed their way of working in response to concerns expressed by governors e.g. in relation to their involvement in the appointment of non-executive directors, and that this had enabled them to move forward positively.

Members

The following table provides data on the size and composition of the membership in the organisations we studied.

Trust	Total at authorisation	Total at December 2007	Patient/public	Staff
Birmingham Women's (authorised February 2008)	3,712	3,712	2,233	1,479
Bradford	2,264	47,008	42,126	4,882
Derby	8,437	15,826	9,006	6,820
RDE	9,112	19,519	13,558	5,961
South Essex	6,973	10,472	10,553	2,000
UCLH	8,769	12,334	5,365	6,969

As the table shows the size of the membership in the five established NHS Foundation Trusts varied from around 10,000 to 47,000 at the end of 2007. All of these organisations had increased their membership since authorisation and all had adopted a policy of staff opting out of membership (though one had started with an opt in policy). Most had plans to increase the membership in future.

One of the challenges faced by the applicant NHS Foundation Trust visited in Birmingham was how to recruit members in a community in which there were already several NHS Foundation Trusts. Partly because of this, and also because of the specialised nature of the services it provides, this Trust was planning for a membership of around 3,500 on authorisation, though it aimed to increase the membership over time.

It was clear that within our sample, there was a variation in the importance that Trusts attached to recruiting members. In some cases, the cost and other human resources involved in recruiting a large membership were cited as barriers to growth. In others, for example South Essex, the recruitment of members was seen as central to establishing the Trust's credibility as a community based institution.

Various strategies were being used to increase membership. Governors themselves were often actively involved in this work and most organisations had a committee of the board of governors focused on membership development. Attracting new members was recognised as a 'hard slog', 'labour intensive' and 'resource hungry'.

Staff leading this work were resorting to a range of approaches, including direct mailing, providing information about membership to patients when they use services, and using governors who had a particular interest in membership recruitment. Birmingham Women's Health Care NHS Trust found that recruiting members through local newsagents had been effective, as had attendance at a large Muslim conference.

There are significant costs to recruiting and maintaining a sizeable and engaged membership. However this cost is small in comparison to any of the sample organisations total budgets. In addition, as one trust has identified, a large and engaged membership need not necessarily be a drain on income, as it can both improve corporate performance and provide a source of innovation.

Basic information about the characteristics of members was held in the Trusts and was used to assess the degree to which the membership was representative of the populations served. This information is required by Monitor, but it is not clear that it has yet been put to any particular use by the regulator. One issue identified in Monitor's approach was that specific categories of data were only required for public members and not patient members.

Some trusts were using information about membership to attract groups in the population who were not well represented e.g. younger people and people from minority ethnic groups. Others felt that representativeness was not a priority and were focusing on how best to use the members they had attracted. The following examples illustrate how this is being done.

Member Information in RDE

Whilst the statutory requirement for foundation trusts is only to keep the name, address, gender and constituency area of public members on file, RDE have chosen to collect additional information to help them ensure a representative membership and engage better with their members. This includes age, ethnicity, disability, desired levels of participation and health interests. This information is not required to become a member, but is collected if the member is willing to give it. It was felt that the information on participation helps members to realise what is on offer, as well as allowing the trust to differentiate their approaches to different kinds of members accordingly. This said, in practice they have found that there is a mismatch between what members say they want to do and are actually prepared to do. Whilst the information on health interests has not yet been used, it is thought that it will be useful for finding people to help with staff projects.

Member Profiling in Birmingham

To assist in the development of its membership, Birmingham Women's Health Care NHS Trust used an external organisation to analyse the profile of its membership in the process of applying to become a Foundation Trust. This involved analysing the demographic and income profile of the public member database, and comparing this with the catchment population, using established profiling methods. The results showed that poorer families were dominant in the public member base, and black ethnic and Asian groups were over represented. In addition, public members were younger than the population as a whole.

Recruiting Young Members in South Essex

South Essex has made an active effort to recruit younger members through its Young Supporters programme. A key part of this has been allowing members to join as early as the age of twelve, as well as holding a number of events at local schools. These have included a parents' event in one school on eating disorders, as well as ongoing work at another to promote positive mental health, combat stigma and promote recruitment to the trust. A local school also performed a play entitled 'Sam Jones – Suicide or Homicide?' at their Annual Members' Meeting. These efforts have been of significant value in membership recruitment, and South Essex now has approximately 1,000 members under 20, which compares favourably with other foundation trusts.

One of the roles of members is to elect governors. In almost all cases elections were contested, although there were examples where governors were elected unopposed and less commonly of a lack of candidates for elections, leading to temporary vacancies on some boards. Turnout at elections ranged from 15% to 55%.

Trust	Election Turnout 04	Election Turnout 05	Election Turnout 06	Election Turnout 07
Birmingham Women's	n/a	n/a	n/a	15%
Bradford	46%	29%	n/a	35%
Derby	29%	21%	31%	25%
RDE	55%	47%	49%	45%
South Essex	n/a	n/a	16%	16%
UCLH	28%	27%	23%	20%

In the established NHS Foundation Trusts, members were reported to be undertaking a common core set of activities. As well as taking part in elections, these activities included receiving information about the work of their organisations,

typically through regular newsletters and letters from the Chair, participating in events such as seminars (e.g. Medicine for Members seminars) and the AGM, and being asked for their views on the services provided and developments under consideration. The experience of Derby Hospitals NHS Foundation Trust illustrates this:

Involving Members in Derby

Membership Communications – "Interactions"

As a first wave Foundation Trust, Derby Hospitals was one of the first FTs to launch a comprehensive membership publication under the name of "Interactions". This quarterly publication includes a wide range of topics and articles on the services the Trust provides, latest clinical developments and capital projects, particularly progress relating to the new hospital. The publication also contains regular reports from the Board of Directors and Council of Governors, as well as healthy lifestyle articles, some of which seek views from members both in the form of questionnaires and responses to articles. Copies of the publication are issued to all public members and copies are available around the hospital both for staff and visitors. The feedback from members suggests that the publication is of continuing interest and is particularly informative.

Medicine for Members

The Trust embarked on programme of lectures or talks given by consultant staff and senior management on various subjects including aspects of clinical work, and service developments. These talks are usually held at either the Derbyshire Royal Infirmary or the Derby City Hospitals and have included the work of the Accident and Emergency Department, Pain Management, Women and Children's Services, Bowl Cancer, Maternity Services, Hypnotism (presented by one of our Consultant Anaesthetists), and the New Hospital Development. The latest programme of events for 2008 includes several of the above along with Breast Cancer, Prostate Cancer and Charitable Funds – how they are used and fundraising. These events are primarily for existing members although the Trust has found that non-members hear from others and join up as members so enabling them to attend. The talks, which are held in the evening, give the members every opportunity to raise questions with those staff who are involved in providing the services

Special Open Day Presentation for Members - Control of Infection

The Trust organised a full day seminar/lecture for members to receive information and explanations about the various hospital acquired infections (HAI) particularly MRSA. The day involved a series of presentations by leading clinical staff and also included a discussion forum which was chaired by a representative from the Trust's Council of Governors. The feedback indicated that the day had given Trust members the opportunity to ask questions regarding HAI and for the Trust to explain some of the myths surrounding what is a controversial issue.

Another example of member involvement comes from Royal Devon and Exeter where effort has focused on strategy formulation:

Involving Members in formulating strategy in RDE

RDE have sought to create an iterative process to formulate trust strategy, which integrates the desires and needs of its membership into the process. The first stage was to send out a questionnaire to 5,000 public members and its entire staff, with a response rate of 42% for public members (but significantly lower for staff). Members were asked to identify their top five priorities, which were identified as 'eliminating waits,' 'infection control,' 'hospital cleanliness,' 'meeting targets,' and 'food and nutrition.' It was felt that the popularity of meeting targets may have been the result of their communications, which consistently talked of their success in achieving this goal.

The next stage was to hold focus groups with members. It was felt that it was necessary to treat patients with respect throughout this process, explaining the situation that the hospital faced, as well as explaining what was and was not feasible. An example of this was the focus group held on infection control, which was believed to have been as much about myth busting as seeking suggestions. Focus groups were run in a practical manner, seeking concrete suggestions as to how these priorities should be delivered.

One example of where the process has delivered significant input into strategy is with regards to the goal of eliminating waits. What the survey and focus groups have told the Trust is that if a GP says that someone needs to see a specialist, they are generally prepared to wait a month. Equally, people are generally prepared to wait about a month for a routine operation. However, they do believe that diagnosis and test results should be much quicker, a priority that the trust has taken on board.

Governor/Member Relationships

One of the challenges facing NHS Foundation Trusts is to establish effective relationships between governors and members. Constituency meetings were used in some organisations for this purpose, enabling governors to meet with members in different areas. While some of these meetings were reported to be well attended, many attracted only a handful of members and were not thought to be worthwhile. One organisation that had used constituency meetings effectively was extending this approach to non-executive directors and linking them with governors in their area

Governors from a stakeholder background such as the voluntary sector seem to be better placed to relate to their constituencies than governors elected by the public or patients (often because they can communicate with established and active organisations). We heard varying views from stakeholder governors about the expectations of the organisations from which they were drawn, with some providing regular feedback and others having limited contact on NHS Foundation Trust issues after their appointment.

We also heard that some governors were reluctant to relate to members through constituency meetings because they did not feel comfortable working in this way e.g. because they lacked information they might need to respond to questions raised by members about the Trust's services. Because of this, some organisations were not using constituency meetings and were instead exploring other ways of communicating with members. In these organisations, governors were described as representatives and not delegates.

The organisations involved in this review appeared to be gaining confidence about the best way of working with members as they acquired experience of so doing. This included recognising that different members wanted different degrees of involvement. Despite this, there was less clarity about the role of members than the role of governors. Part of the learning in the early years of NHS Foundation Trusts has been understanding what it means to be a membership organisation and the need to resource this properly.

LESSONS ON MEMBERSHIP FROM THE MUTUAL SECTOR

There appears to be a continuing need to ensure clarity about the role and importance of membership. Where clarity does not exist, recruitment may be difficult.

Within the mutual sector, this issue is typically addressed by segmenting the membership, not only in terms of raw numbers and demographic characteristics, which Trusts appear to generally do well at (see below) but also by activity and motivations. Once these factors are understood, the focus of recruitment is much clearer, with less emphasis on factors that only motivate a small minority of members.

The following tables and diagrams attempt to consider NHS Foundation Trust membership in this way. An imaginary trust with a potential membership population of 200,000 people and a total combined membership (most staff would be local) of 20,000 would typically have a membership that could be segmented in the following proportions:

200,000 Membership Pool

Member Category	Proportion of potential membership/actual membership	
Potential Members (yet to join) 180,000	90%	n/a
Inactive members 14,000	7%	70%
Armchair Activists 3,000	1.5%	15%
Active Citizens 2,750	1.4%	14%
Democrats 200	0.1%	1%
Elected Governors 50	0.03%	0.3%

Segmenting membership - definitions

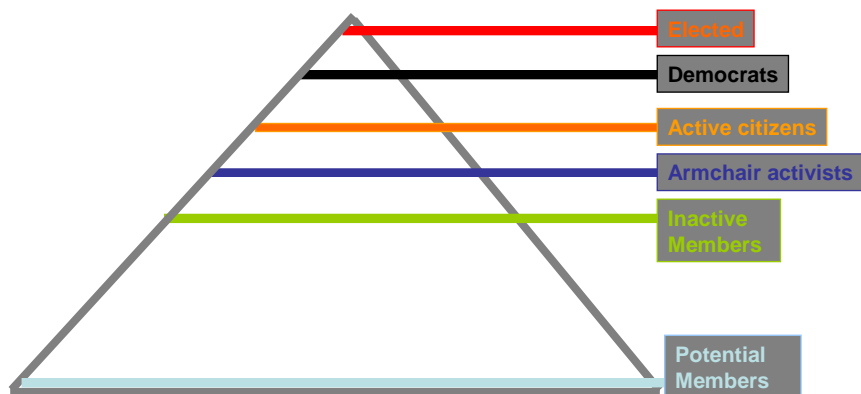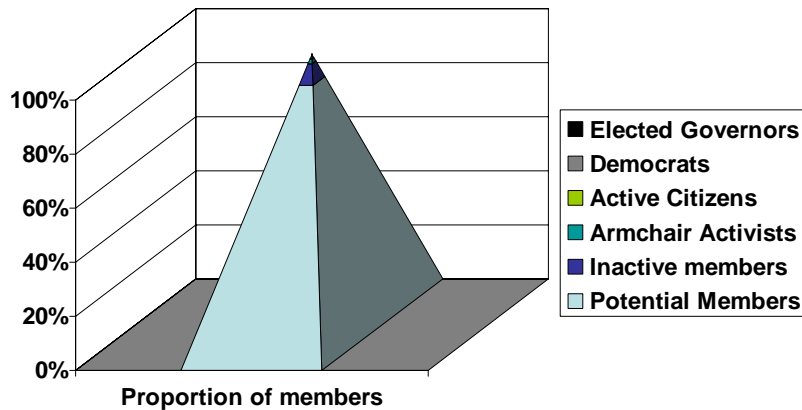|	
Potential Members	Qualified to join but have not yet done so
Inactive Members	Happy to 'wear the badge' of membership, but little more
Armchair Activists	Happy to be kept informed or participate in "convenience activism"
Active citizens	Will usually vote and engage if motivated by particular issue especially on campaigning or community theme
Democrats	Will usually vote, and occasionally nominate – might also stand for election
Elected	Successfully elected Governors

**The membership pyramid –
Segmenting foundation trust
Members by category**

What this looks like in our typical trust

These diagrams bring into focus the 'facts of life' of most membership organisations, namely:

- Only a proportion of those eligible/able to join will do so
- Of those that do join, the majority will be passive members
- Those that become active will therefore only represent a small proportion of the total potential membership and a minority of the actual membership

NHS Foundation Trusts are no different and there is one important lesson about the art of membership recruitment that all Trusts must learn. This is that in order to recruit successfully, one must first understand the motivations of likely members according to the segmentation of existing members. If the membership 'sell' is all about democracy and standing for elections, it will only yield small results – there are simply too few people interested in this aspect. A much more successful approach is to tap into the significant interest in 'showing support' for trusts.

Many mutuals have foundered in the past on only serving a small class of activist member, to the detriment of the larger mass of members. This must be avoided and strategies must recognise the different membership segments.

Board of Directors/Board of Governor Relationships

The two tier governance structure of NHS Foundation Trusts, involving the oversight of the board of governors and the corporate leadership role of the board of directors, is unusual in British public services. As the early guidance issued by the Department of Health recognised (see above), the structure could lead to confusion and conflict if there is not clarity about the role and powers of each board and how they relate to one another.

The organisations we visited told a story of how these issues had played out in practice. In some cases it had proved possible to establish a *modus vivendi* quite quickly, while in others there had been tensions and difficulties in the early days. It was reported that these difficulties had progressively been overcome as greater understanding of governance arrangements was established e.g. the work done in Derby to define the role of governors referred to earlier.

In all organisations there are arrangements for the two boards to meet from time to time. This takes a number of forms, including formal board to board meetings, for example on strategy and forward plans, informal roundtable discussions, and directors and governors attending each other's meetings. Executive as well as non-executive directors attend board of governors meetings, often to make presentations or to talk to papers that have been circulated.

The following example from UCLH illustrates how dialogue between the two boards has made a difference to patients:

Board to Board Relations in UCLH

Over a year after authorisation, a joint development day was held between the Governing Body and the Board of Directors, at which one of the Governors gave a presentation entitled 'the patient experience.' It tackled the non medical problems that patients of the trust faced with an emphasis on appointment booking systems, getting through on the telephones, and courtesy. Whilst these were not trust targets, it was argued that these could be almost as important to patients as the medical treatment that they received.

The response of the Board of Directors was to draw up a service charter. Entitled 'Putting Patients First,' it committed the staff of the trust to:

- Be friendly, helpful and welcoming
- Introduce themselves by name and role, and explain what they do
- Give each person their full attention
- Anticipate the needs of patients and visitors
- Take time to listen and find out what people really want or need
- Respond promptly and do what they have promised
- Be well informed and pass on information
- Treat everyone with respect, apologising if appropriate
- Offer to help, not wait to be asked
- Find someone to help if they aren't able to

This was rolled out to the staff through a number of training sessions designed to improve performance along these lines.

This also led to the creation of a 'patient experience' governor working group. This has dealt with issues such as service commitment, attitudes at reception and transport, and has also surveyed the membership to find their priorities for improving on these types of issues at the trust. This has fed into a number of changes in trust strategy, including the extension of outpatient clinic hours until eight in the evening. The survey has also touched on their membership experience, leading to an increase in the frequency of the newsletter from 3 to 4 times per year.

The experience of governors attending meetings of boards of directors has been variable. In one of the NHS Foundation Trusts we visited, governors no longer attend these meetings as it is felt this risks confusing the different responsibilities of governors and directors. In another, governors are able to attend the board of directors if they wish, but in practice rarely do so. In South Essex, governors are invited to board of directors' awaydays.

South Essex has found value in governors and directors working together in project groups. Five groups have been established on stigma, social inclusion, volunteering, employment, and membership communications. Directors chair these groups and membership includes executives, non-executives, governors and staff.

The Chair's Role

Of critical importance in the development of effective relationships is the role of the Trust chair who has the responsibility of chairing both boards. In this role, the chair is in effect the lynchpin of the Trust, having a relationship with the membership through the governors, and a relationship with the organisation through the directors.

Where the chair is able to adapt his or her style to the needs of two quite different boards, then governance arrangements seem to be working well. Specifically, this requires chairs to have excellent inter-personal and listening skills, and the ability to facilitate the range of interests and people who typically come together on boards of governors.

In some cases chairs have not always been successful in doing this, and this has led to confrontation and disagreement with governors. This has occurred particularly where chairs have been perceived as too 'controlling' and unwilling to be flexible in working with governors, perhaps because of inexperience of leading this kind of board.

The annual appraisal of the chair provides an opportunity for these issues to be reviewed. NHS Foundation Trusts have discretion in deciding whether and how to involve governors in the chair's appraisal. Some organisations involve governors through the vice chair of the board of governors who provides feedback either individually or on behalf of the board as a whole to the senior independent director undertaking the appraisal.

The challenge made by governors has led some chairs to reconsider their role and how they communicate with governors, and this has contributed to improvements in relationships. In other cases, chairs have not made the adjustment, with the risk that their own position will be in question at the time of reappointment. It is in this context that the power of governors to appoint the chair assumes particular importance.

Although no group of governors has yet exercised their ultimate powers by removing (or failing to re-appoint) a willing chair, they have been involved in re-appointments and new appointments. In one organisation, the governors reported that a change in the chair was instrumental in making them feel more involved and valued. This had included the chair working closely with the vice chair of the board of governors in agreeing agendas for meetings and changing the way of working to make it more open and participative.

The importance of the chair's role, and the different dynamics of the two boards, has led some to suggest that the role should be split. We return to discuss this in our conclusions.

The Company Secretary

Alongside the chair, the company secretary (this terminology is used here to describe the roles performed by board secretaries and trust secretaries too) has a pivotal role in the governance arrangements of NHS Foundation Trusts. The person taking on this role has to look outward to the membership and the wider community,

as well as inward to the organisation and its senior staff. Put another way, the company secretary is involved both in engaging the public in the work of the Trust as members and governors, and ensuring compliance with governance requirements and the terms of authorisation.

As far as governance is concerned, one of the roles of the company secretary is to prepare agendas for meetings of the board of governors and to organise papers. This is usually done in association with the Trust chair. In most organisations governors themselves are able to request that items are put on the agenda through the chair. In one of the organisations visited, agendas for governors' meetings are set by the governors themselves.

The company secretary is usually supported by one or two members of staff whose role is to keep in contact with the governors and members. These staff are often the main point of contact for governors and members and their role is important in ensuring that governors and members are well informed about the Trust's work, and are engaged in meetings and other activities.

Where they exist, membership managers are highly valued by governors and members. One of their roles is to take a lead in the development and implementation of membership strategies. Membership strategies are required documents for the authorisation process. They have developed over the last three years as Trusts have gained a better understanding of the requirements of managing membership.

The company secretary performs a number of key functions in the governance of NHS Foundation Trusts, including:

- supporting the governors in the discharge of their statutory responsibilities e.g. in the appointment of the chair and non-executive directors

- arranging for the election of governors (usually with the support of the Electoral Reform Society)

- maintaining and updating the register of members (this is often contracted out to an organisation like Computershare)

- ensuring that the board of directors and the board of governors comply with the Trust's constitution, standing orders, code of governance, etc

- organising training and support for governors, and members as appropriate (see below)

- organising the annual general meeting

In one of the organisations visited, the company secretary role was split between the board secretary and the head of corporate affairs. The Trust concerned felt that this was not an effective arrangement of responsibilities and was therefore considering combining these posts.

It is important to recognise that there are differences in the role of the company secretary in membership and mutual organisations:

The Role of the Mutual Secretary

In any mutual, the role of the secretary will be slightly different from that required in a traditional company. This is a key factor that must be taken into account when constructing the executive team at any foundation trust. The principal difference relates to the operation of the democratic governance structure. In addition to the specific additional tasks that are connected with ensuring that the mechanics of membership governance works, the secretary must be able to operate at a political level within the organisation.

As outlined above, adapting to the new role of the chair is a critical element in the success of a foundation trust. The main management support for the Chair is from the Secretary, and this must include a sophisticated understanding of the political dynamics at play within the governance structure. Equally, the Secretary will be the senior manager to whom the governors and members relate. They will be a useful player in helping to manage the relationships between stakeholders, and act as an early warning for the Chair when issues arise.

It therefore requires a person with strong interpersonal as well as organisational skills, able to judge both the mod of stakeholders but also understand the interplay between the Chair and Chief Executive within the Board structure.

These differences must be acknowledged in the way in which the company secretary role is defined in NHS Foundation Trusts and the kinds of people appointed to the role.

Training and support

NHS Foundation Trusts in the first two waves received financial support from the Department of Health to assist with the costs of establishment. Each organisation was allocated £175,000 and the organisations we visited reported that some of this money was used on governance issues e.g. the recruitment of members and the cost of elections of governors. The applicant NHS Foundation Trust visited received no central support.

All organisations provide induction for governors, and some opportunities for continuing training and development. The most comprehensive example we found was in South Essex where a thirteen module programme had been developed.

Governor Training in South Essex

Module Number	Objectives
1	- Information about development program - Introduction to the Trust
2	Introduction to the governance arrangements of NHS Foundation Trusts
3	- Debate the role of governors - Agree priorities for the future - Introduce projects suggested by the Board of Directors
4	Introduction to: - Audit and auditors - Finance - Remuneration of non-executive directors - Compliance framework
5	- Presentation by Chief Executive on the performance of the Trust over the previous quarter - Action planning of priorities identified at Governor Development Program Modules 3 and 4
6	- Presentation on mental health and learning disability issues and service provision - Discussion of governance issues
7	- Presentation on 'Managing our time' - Presentation by the learning disability service
8	Presentations by the Adult Mental Health Service and the Forensic Mental Health Service
9	- Code of Governance - Role of Governors
10	Presentations from the external auditors and the CAMHS Service
11	Presentations from the Drugs and Alcohol service and the Older People's Services
12	- Reviewing Induction Programme for Governors - Discussion regarding future Governor development
13	- Introduction to Governor web pages - Review of action plan and networking meetings

In the other organisations, governors were offered specialist training where appropriate e.g. from the HR department of the Trust on their role in making appointments. Optional development days were also commonly available e.g. on 'hot topics' within the Trust, though uptake was reported to be patchy. Governors we spoke to were almost universally positive about the training they had received.

In one organisation, newly elected or appointed governors were linked with an experienced governor as part of a 'buddy' programme to assist with their induction.

The training and support on offer from other organisations received mixed reviews. Monitor was not seen to have given priority to membership governance issues until recently and was therefore not viewed as having made a significant contribution in this area (in contrast to Monitor's influence on other aspects of NHS Foundation Trust performance).

The FTN was perceived to have played a bigger part in organising seminars and conferences of relevance to governors and directors, although the timing of these meetings and the variety of experience of participants lessened their value for some. The Department of Health was reported to have provided valuable support to some organisations during the application process, although increasingly this role is being taken on by others e.g. SHAs. It was felt by a number of trusts that they had not received sufficient support from Monitor, the Department of Health or the Foundation Trust Network in this regard.

Other sources of external support were (1) lawyers who contributed specifically on issues to do with constitutions and related matters, (2) Mutuo which had been used by some organisations in the development of membership strategies, and (3) other NHS Foundation Trusts which were reported to have offered useful support where this kind of advice had been sought.

Public and patient involvement

As described in the introduction to this paper, a major part of the rationale behind NHS Foundation Trusts was a desire to devolve power within the NHS and establish stronger connections between NHS services and local communities. It is for this reason that members are the owners of NHS Foundation Trusts and governors are elected to represent the interests of members in the governance arrangements that have been established. These arrangements co-exist with a number of other mechanisms for patient and public involvement and scrutiny of NHS decision making, such as patients' forums and local government overview and scrutiny.

People interviewed as part of this review expressed divergent views on the coherence of these arrangements, ranging from concern that there was overlap and duplication to a perception that the NHS benefited from having many different channels for patients and the public to express their views and participate in decision making – a 'vibrant system of engagement' as one chief executive put it.

Notwithstanding these differences, there was broad agreement that the involvement of members and governors in NHS Foundation Trusts was a profound change which the directors and staff of Trusts had been slow to appreciate at the outset but which was becoming increasingly apparent with the passage of time. Not least, it made directors and staff more aware of the views of patients and the public than had previously been the case, and it provided them with a legitimacy that had been lacking in the past.

The Patient Experience in RDE

At Royal Devon and Exeter, it was felt that the most important part of the Foundation Trust experience was the direct route to the public that this had given to them and that it had made a real difference to how they tailor their service. Before they had managed the system and created a good technical strategy, but no more. While their technical strategy continues, they are now looking to shape services into 'human form,' through investing their £4 million surplus in areas that the public want to see the most change. One of the cornerstones of this strategy is the Trust's long term objective of accommodating all patients into single rooms, which was seen as fitting in with not only what patients want in terms of service, but also the clinical goal of reducing the spread of infection.

A different example concerns the involvement of young people in Bradford:

3G at Bradford

In 2005 Bradford launched 3G: From the Cradle to the Grave, a special project aimed at increasing involvement in the Foundation Trust from young people across the district. Governors are currently working with the Foundation Trust's Training and Education department and Human Resources department to support young people who are interested in working in the NHS and those interested in health issues that affect young people. As part of this work a three part pilot programme has been developed involving information sessions, careers days and the delivery of a large scale student health fair event. Students will find out about the wide range of careers and job opportunities in the NHS, volunteering opportunities for young people and how to access work experience and training courses at the Foundation Trust. The Health Fair will be delivered by the Foundation Trust with participation from Bradford College, the Universities of Bradford and Leeds, Education Bradford and Careers Bradford. Aside from a focus on jobs, education, training and careers, the health fair is aimed at increasing awareness of health priorities amongst the young and provides support for the delivery of the high schools health care curriculum.

Chief executives in particular emphasised the difference membership had made, sometimes expressing (pleasant) surprise at the impact governors and members were making within their organisations. Having made this point, it was also widely recognised that the current arrangements for recruiting members and electing governors are a work in progress. Similarly, there is understanding that directors and staff are still learning how to make the best use of governors and especially members. In this respect, the NHS has taken but the first step on a long journey designed to strengthen local accountability as the line relationship between the Department of Health and NHS service providers is broken.

The existence of around 1 million members at the end of 2007 and the potential this creates to recast the relationship between the NHS and the public should not be underestimated. Four years into the NHS Foundation Trusts story, it is surprising that more has not been made of the quiet revolution that has taken place, although

the recent announcement by the Prime Minister that the number of members of NHS Foundation Trusts should increase to 3 million by 2012 is an important straw in the wind.

As we noted earlier, NHS Foundation Trusts themselves have been cautious about making too much of what has been achieved so far because so much more remains to be done. The implications of being a membership organisation are increasingly understood, as are the changes in behaviour that are needed to turn this into reality. There may also need to be changes in the policy context to follow through the logic of the model that has been established.

In relation to patient and public involvement, this includes asking whether NHS Foundation Trusts should be required to make use of the same mechanisms of involvement as NHS organisations that are not NHS Foundation Trusts. The role of the members and governors could be considerably strengthened if they were the principal channel through which NHS Foundation Trusts related to their communities, rather than, as at present, one channel among many. Paradoxically, and perhaps unintentionally, the radicalism of the NHS Foundation Trust model may have been hamstrung by not following the model through to its logical conclusion, and enabling Foundation Trusts to decide how they wish to relate to patients and the public.

What then might be done in this area and others to build on progress made to date?

4. Conclusions

The findings reported here tell a story of progress since the reviews undertaken by the Healthcare Commission, the Nuffield Trust and the King's Fund. In comparison with these early studies, our snapshot of six organisations at the end of 2007 indicates that the unusual hybrid governance model adopted for NHS Foundation Trusts is working increasingly effectively, and leads us to the following conclusions:

- in line with expectations, and as Day and Klein (2005) noted in their study, there is a diversity of governance arrangements in NHS Foundation Trusts, within the statutory framework laid down by Parliament e.g. in relation to the size and composition of the board of governors and the membership

- there is increasing clarity on the role of the board of governors and how the knowledge and skills of governors can be used to best advantage

- the statutory powers of governors have helped to ensure that they are taken seriously and are not treated as a rubber stamp, as some had feared

- an increasing number of governors appear to be active participants in the work of NHS Foundation Trusts, although more needs to be done to engage stakeholder governors

- staff governors are often an under-used resource. Their contribution should be a higher priority for NHS Foundation Trusts and HR departments should make use of their experience and credibility

- NHS Foundation Trusts need to provide greater clarity on the role of the membership community and continue to develop the most effective ways of governors relating to members

- constituency meetings between governors and members have met with varying success and NHS Foundation Trusts need to consider a variety of approaches to ensure that governors and members relate effectively

- NHS Foundation Trusts are communicating with members through magazines and newsletters and letters from the chair, and are increasingly using more interactive ways of engaging members such as through questionnaires and surveys, focus groups and project work

- the Trust chair is the lynchpin in the governance arrangements of NHS Foundation Trusts, and the way in which he or she undertakes this role has a major bearing on how these arrangements work in practice

- the Trust chair has to be able to lead the work of the organisation through the board of directors and relate to the membership through the board of governors. Experience suggests that each role needs a different style, requiring chairs to be adaptable in the way they function

- while there is an argument for the role of chair to be split, we do not believe this is the best way forward. The chair provides the link between the business of the NHS Foundation Trust and through the governors and members, the community it serves. Creating a separate chair of governors would risk the governors developing a scrutiny function which might dilute the mechanisms for accountability to the membership. The arrangements we encountered in one Foundation Trust of the chair working closely with the deputy chair of the board of governors is an alternative way of working, and there may be others

- governors need to be involved in the appraisal of the chair to ensure that any issues around the chair's role are identified and addressed before they become more significant

- the company secretary also has a key role in the governance of NHS Foundation Trusts and with his or her staff is usually the main point of contact for governors and members

- realising the full potential of NHS Foundation Trusts is likely to mean strengthening the role of the secretariat and providing additional resources for this function

- training and support for governors is needed on induction and on a continuing basis to ensure that governors are equipped with the knowledge and skills they require

- arrangements for patient and public involvement in NHS Foundation Trusts may need to be reviewed to ensure that national policy in this area does not unintentionally hinder the development of governors and members

- developing a sizeable and engaged membership requires a sustained commitment of resources to membership services. The rewards of such investment, in terms of services delivered in ways that much more reflect local people's needs, will greatly outweigh its costs.

In summary, our view, based on the evidence available to us, is that governance arrangements in Foundation Trusts are now established and are becoming increasingly effective. More positively, there is untapped potential in the recruitment of 1 million members and more than 2,000 governors in creating a quite different relationship between the NHS and the communities it serves.

In this regard our findings accord more with the views of Lowe-Lauri (2008), based on his experience at King's College NHS Foundation Trust, than the findings of the research undertaken by Lewis and Hinton (2008) at the Homerton University Hospital NHS Foundation Trust in 2004/05. The difference between our findings and those of Lewis and Hinton may well be explained by the larger number of organisations included in our review and the more recent evidence we have been able to draw on.

In the next stage of the Foundation Trust story, the challenge is to build on the start that has been made and to find more effective ways of engaging with members and reconnecting the NHS with the public.

5. References

P Day and R Klein (2005) Governance of Foundation Trusts: Dilemmas of Diversity, The Nuffield Trust, London

DH (2002) A Guide to NHS Foundation Trusts, Department of Health, London

DH (2004) NHS Foundation Trusts: a guide to developing governance arrangements

Healthcare Commission (2005) The Healthcare Commission's Review of NHS Foundation Trusts, Healthcare Commission, London.

Monitor (2004) NHS Foundation Trusts: Report on Elections and Membership

R Lewis (2005) Governing Foundation Trusts: A New Era for Public Accountability, King's Fund, London

R Lewis and L Hinton (2008) Citizen and staff involvement in health service decision making: have National Health Service foundation trusts in England given stakeholders a louder voice? Journal of Health Services Research and Policy, 13: 19-25

M Lowe-Lauri (2008) Foundation trust governors can and should exercise their influence in the wider community to benefit service users. Health Service Journal, 13 March

Foundation Trust Network (2007) NHS Foundation Trusts: The Story So Far, NHS Confederation, London

6. Appendix: Interview Schedule

Review of Mutuality Arrangements in NHS Provider Organisations

Background paper for visits to be undertaken by Chris Ham and Peter Hunt in September and October 2007.

The review is designed to understand the nature of governance arrangements in Foundation Trusts (and an NHS Trust about to become a Foundation Trust). The following questions will be explored during visits to NHS organisations:

1. What are the governance arrangements in the organisations included in the review? *It would be helpful to receive information on these arrangements in advance of our visits.*

2. How big is the membership in each organisation and how has the size and composition of the membership changed over time? What information is held about the membership?

3. What roles do members play?

4. How does the organisation communicate with the members and involve them in its work? Are there any examples of innovation in this regard?

5. Does the organisation have a membership strategy? If so, who leads on the strategy, and what level of resources have been put in place to support it?

6. What has been the experience of elections to the board of governors? What is the turnout in elections for patients, the public and staff? What proportion of seats has been contested? What is the average number of candidates standing for election?

7. What is the size and composition of the board of governors? How often does the board meet? What is the average attendance rate at meetings? What is the content of board agendas and how are these constructed?

8. What is the relationship, if any, between governors and their 'constituencies' i.e. the members who elected them or the organisations from which they are drawn?

9. What training and support is provided to governors?

10. Was support and funding provided by the Department of Health in the development of governance arrangements? If so, how was this support and funding used?

11. What is the nature of the relationship between the board of governors and the board of directors?

12. What has been the experience of the Chair in relation to each board and combining this role on the two boards?

13. What is the role of the company/board secretary?

14. What is the nature of relationships with local authorities, including the role of the local authority stakeholder governors? What contact has there been with overview and scrutiny committees?

15. How does patient and public involvement in the organisation through the membership and governors relate to other forms of patient and public engagement in the NHS e.g. LINks?

16. What suggestions do interviewees have for changing and improving governance arrangements?

17. Are there other issues that interviewees wish to raise?

Chris Ham and Peter Hunt
September 2007.