

NHS Foundation Trusts

**A sourcebook for developing
governance arrangements**

Foreword

The aim of this document is to help NHS foundation trust applicants develop their governance arrangements in conjunction with expert advice and support from the Department of Health's NHS foundation trust Unit and other specialist bodies.

The document is intended to be a brief and easy to read introduction to the NHS Foundation trust policy and implementation programme. It provides key facts on NHS Foundation trusts, sets out the reasoning behind the policy and gives information on the principles supporting the way the Trusts will be governed. It also presents case studies showing approaches applied in other areas.

It is a sourcebook that is intended to provide a catalogue of good practice and the available evidence base from other sectors will help managers design their own structures within the existing legislation. These links are important from several perspectives because they offer the opportunity to:

- share learning about what works, and what does not;
- share the expertise of potential members and stakeholders;
- harness the participation of the community in a variety of ways, particularly around health promotion, self-help approaches to health and citizen involvement in decision making process.

This source book is not intended to be a static document. This is the fourth edition and will continue to be supplemented with learning from the experience of the previous applicants. It has been amended to reflect the legislation as it emerged in the Health and Social Care (Community Health and Standards) Act 2003.

The Department of Health welcomes comment and real working examples that will help NHS foundation trusts develop their governance arrangements so that they can deliver genuine local accountability.

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1. What are NHS foundation trusts?

1.1 A new type of NHS hospital

The introduction of NHS foundation trusts (often referred to as “foundation hospitals”) represents a profound change in the history of the NHS and the way in which hospital services are managed and provided. The shift of accountability from central government means that local communities and staff are being given a bigger say in managing NHS services in their area.

NHS foundation trusts remain fully part of the NHS. They have been set up in law under the Health and Social Care (Community Health and Standards) Act 2003 as legally independent organisations called Public Benefit Corporations, a new kind of organisation based on mutual traditions. Their primary purpose is to provide NHS services to NHS patients according to NHS principles and standards. The public still experience healthcare according to core NHS principles - *free care, based on need and not ability to pay*.

The first NHS foundation trusts have been up and running since 1 April 2004 with Trusts coming on-stream on that date and at regular intervals thereafter.

NHS foundation trusts establish stronger connections between local hospitals and their local communities. Local communities have social ownership of their NHS foundation trust. Those living in communities served by a hospital of an NHS foundation trust will be invited to become a member. The membership community of each NHS foundation trust is made up of local people, staff, patients and their carers. To strengthen links with the local communities NHS foundation trusts also have representation from primary care trusts, local authorities and the University where the NHS foundation trust hospitals include a medical or dental school. In addition, the NHS foundation trust can designate one or more organisations as ‘partner organisations’.

Members are able to stand and vote in elections for governors of the Trust. Primary care trusts, local authorities, universities and partnership organisations are all entitled to appoint a governor to the board. These governors are appointed directly by the organisation and not the trust. Governors are responsible for representing the interests of the members and partner organisations in the local health economy in the governance of the NHS foundation trust. This sort of social ownership and accountability ensures that hospital services more accurately reflect the needs and expectations of local people.

NHS foundation trusts have been set free from central Government control, manage their own budgets and are able to shape the healthcare services they provide to better reflect local needs and priorities. NHS foundation trusts have freedom to develop new solutions to long-standing problems such as staff shortages and long waits for certain treatments. NHS foundation trusts do not work in isolation. They are bound in law to work closely with other organisations in their local area. Health care planning continues to involve the whole NHS community and social care partners, but there is more freedom to develop innovative arrangements between all providers. NHS foundation trusts continue to be inspected by the Healthcare Commission to the same high standards as all other NHS hospitals,

1.3 NHS Foundation trust core principles

NHS foundation trusts are new legal entities – Public Benefit Corporations. These are based on mutual principles giving local ownership and greater involvement of their local communities through their links with their members and their partner organisations. Local people, staff, patients and their carers are able to become members of their local NHS foundation trust.

NHS foundation trusts will be different from existing NHS trusts in three important ways. They:

- have new freedom to decide locally how to deliver services;
- are accountable to local people, who will become members, governors and non-executive directors;
- are authorised and monitored by Monitor, the Independent Regulator for NHS foundation trusts.

NHS foundation trusts will remain part of the NHS. They are required by law to:

- maintain high national standards for NHS services;
- deliver NHS services to NHS patients free at the point of use;
- treat patients according to need, not ability to pay;
- work in co-operation with other health and social care partners.

The primary purpose of NHS foundation trusts is to provide NHS services to NHS patients in England and this will be set out in their terms of authorisation which is determined by the Independent Regulator. NHS foundation trusts are prevented from selling off or mortgaging NHS property and resources needed to provide key NHS services.

1.4 Governance arrangements

A say in how your hospital is run

NHS foundation trusts will strengthen local ownership of - and responsibility for - hospital services. Decisions will be taken by the trust *with* local communities *for* local communities.

Residents in areas served by an NHS foundation trust, including patients and their carers, with an interest in the wellbeing of their local hospital will be invited to register as members of the organisation. NHS foundation trusts may also allow for people living outside of the area served by the NHS foundation trust, to become members.

Members of NHS foundation trusts will not receive any special treatment as NHS patients. They will have the same access to NHS services as anyone who chooses not to become a member.

All NHS foundation trust members can expect to receive regular information about their local Trust and be consulted on plans for future development.

Members will be able to vote in elections to the board of governors of the NHS foundation trust. They will also be able to stand for election as governors, and public and patient members will be eligible to be appointed as non-executive directors on the board of directors provided that they meet the criteria.

The board of governors will be responsible for representing the interests of the local community in the strategic planning and stewardship of the NHS foundation trust, and for communicating with other NHS foundation trust members.

The board of governors will not be responsible for the day to day management of the organisation e.g. setting budgets, staff pay and other operational matters – that will come under the auspices of the board of directors. The board of governors will however enable local residents, staff and key stakeholders to influence decisions about spending and the development of services. The board of governors will also appoint the chair and non-executive directors of the board of directors.

It will be up to each individual NHS foundation trust to determine the detail of the arrangements for the membership and the composition of the board of governors, within certain parameters. In particular, there must be fair and transparent elections. Governance arrangements will ultimately be *tailored to the individual circumstances of each trust*, reflecting the range of diverse relationships with patients, the local community and other stakeholders.

NHS foundation trusts will be allowed some local flexibility over the exact composition of their board of governors. However, every board must have:

- a majority of governors elected by members of the public – that is members of the public constituencies and the patient constituency, if there is one;
- at least three governors elected by staff members;
- at least one governor appointed by local primary care trusts;
- at least one governor appointed by local authorities in the area;
- at least one governor appointed from the local university if the trust's hospitals include a university medical or dental school.

The Chair of the NHS foundation trust is not a governor but will preside at meetings of the Board of Governors.

Becoming an NHS foundation trust member

Eligibility for membership of an NHS foundation trust will be open to local residents, patients and carers and staff employed by the trust, in the terms provided in each trust's constitution. The constitution may provide additional eligibility criteria for membership and this would typically include a lower age limit, and exclusions for anyone involved in any act of violence against staff or other members of the Trust or anyone identified as a vexatious complainant.

Individual NHS foundation trusts may provide for people who live outside the area to be eligible for membership.

There will be no limit on the number of people who can register as members, providing they meet the eligibility criteria.

1.5 Local services, national standards

The Independent Regulator, Monitor, is directly accountable to Parliament.

Every NHS Foundation trust will have an authorisation – like a ‘licence’ to operate - issued by Monitor. The terms of authorisation will set out the conditions under which an NHS foundation trust will operate and will cover such things as:

- a description of the health goods and services that a trust is authorised to provide;
- a list of goods and services that a trust is required to provide to the NHS in England;
- a requirement to operate to high standards, based on the national standards for healthcare against which the Healthcare Commission will inspect;
- the circumstances in which major changes to services (for example, in response to a changing local population) need to be discussed locally and agreed by Monitor;
- a list of assets such as buildings, land or equipment that are designated as ‘protected’ because they are needed to provide required NHS services;
- limits on the amount of private work an NHS foundation trust can carry out. NHS foundation trusts will be subject to strict limits on private patient work based on the proportion of private work carried out in the year to 31st March 2003. If an NHS foundation trust wishes to treat more private patients, it will need to treat more NHS patients *first*. This will ensure that NHS foundation trusts continue to focus on NHS work;
- the amount of money an NHS foundation trust is allowed to borrow;
- the financial and statistical information an NHS foundation trust is required to provide.

Like all other NHS bodies, NHS foundation trusts will be inspected against national standards by the Healthcare Commission. Monitor will receive copies of inspection reports and decide whether action is needed in the event of failings.

Monitor has issued a Compliance Framework which outlines the process he will use for monitoring each NHS foundation trust to ensure that they do not breach the terms of their authorisation. This is based on the fact that the main responsibility for ensuring that NHS foundation trusts comply with both their authorisation and all statutory obligations rests with the board of directors. The role of Monitor is designed to give NHS foundation trusts the freedom to deliver services to meet local needs while safeguarding the interests of NHS patients. Monitor adopts a risk based approach to regulation where the level of monitoring

is based on the risk of the NHS foundation trust breaching their authorisation. In normal circumstances Monitor will have no reason to intervene in the running of an NHS foundation trust.

However, if an NHS foundation trust significantly breaches the terms of its authorisation, or finds itself in difficulty, Monitor has the power to step in to resolve the breach. Monitor has a range of intervention powers, including powers to:

- issue warning notices;
- require the NHS foundation trust, its board of governors or its directors to take certain actions;
- suspend or remove members of the board of governors or the directors of the Trust.

In the most serious cases, where intervention by the Independent Regulator could not resolve the breach, an NHS foundation trust could be dissolved. If this ever were to happen, the *Health and Social Care (Community Health and Standards) Act 2003* provides mechanisms to ensure that NHS patients continue to receive high quality treatment.

1.6 Rewarding results, encouraging growth

Historically, hospital funding has been dependent on the negotiating skills of individual hospital managers in agreeing service levels in block contracts. From April 2005 a fairer, more open financial system of *payments by results* was introduced across the NHS.

The new financial system will:

- reimburse hospitals fairly for the services they deliver;
- reward efficiency and quality;
- ensure services are developed in line with local need;
- give patients more choice about where they are treated;
- allow funding to 'follow' a patient if they decide to be treated in another hospital.

NHS foundation trusts enter into legally binding agreements with local Primary Care Trusts who will buy locally relevant services for the population served by the trusts. These contracts will set out the number and type of services NHS foundation trusts will provide.

If an NHS foundation trust wants to change its services, it must consult the NHS primary care trusts that pay for those services. If the services it wishes to change are classified as essential NHS services which the trust is required to provide under its terms of authorisation, then the NHS foundation trust must obtain the agreement of the Independent Regulator. Should the proposed change in services amount to a substantial development or variation in the provision of the health service then the NHS foundation trust must ensure that persons to whom those services are being or may be provided are directly or through representatives consulted. The Local Authority (Overview and Scrutiny Committee

Health Scrutiny Functions) Regulations 2002 impose an obligation on local health service bodies to consult with the Overview and Scrutiny Committee on any proposal for a substantial development or variation in the provision of the health service within the committee's area that the health service bodies have under consideration.

1.7 Borrowing for growth, protecting NHS assets

NHS foundation trusts will have freedom to decide locally the capital investment needed in order to improve services and increase capacity. They will be able to borrow to support this investment, as long as they can afford it, without needing to seek external approval. Access to the Private Finance Initiative and to public capital for major schemes will continue.

The amount they can borrow will be determined by a formula - the *Prudential Code* - directly linked to their ability to repay the debt from the revenue they raise. Each NHS Foundation trust will calculate their borrowing limit based on this formula. The limit for each NHS foundation trust will be set out in their authorisation and will be subject to annual review by Monitor. Against this borrowing limit, NHS foundation trusts will be allowed to raise finance to build new facilities and improve existing ones. They will be able to borrow money from the Government and from private sector lenders.

As part of the terms of authorisation issued by Monitor, NHS foundation trusts will be required to provide essential NHS goods and services including teaching and research. The property owned by the NHS foundation trust that is needed to continue to provide such 'required' services will be designated as 'protected' by Monitor. In this way, patients can be sure that NHS foundation trusts will continue to be able to provide the NHS services that are needed and commissioned locally. Land, buildings and other assets which are 'protected' in this way, as part of an NHS foundation trust's authorisation, cannot be sold or leased or used as security for borrowing.

1.8 Pay and conditions

Like other NHS organisations NHS foundation Trusts will issue new contracts based on the new NHS pay framework *Agenda for Change*.

As part of *Agenda for Change*, NHS job roles are formally assessed and put into an agreed pay band, ensuring staff are rewarded fairly for the skills they have and the work they do.

Achieving NHS foundation trust status will not affect the continuity of service of staff. Staff working in NHS foundation trusts will have full access to the NHS pension scheme and other NHS benefits.

NHS foundations trusts will be able to develop a range of local initiatives. They will be encouraged to create new types of jobs, new ways of working and more

flexible shift patterns to meet local needs and will have the freedom to develop innovative reward packages to retain and attract staff. Most NHS foundation trusts will use these freedoms sensitively to avoid destabilising the local health economy.

1.9 Qualifying for NHS foundation trust status

To be eligible to apply for foundation status, NHS organisations must:

- be an acute, specialist, mental health NHS Trust, or care trust (in the future foundation status may be available to other types of NHS trusts);
- hold a three or two star rating in the annual NHS performance ratings and maintain this throughout the application process;
- prove that they have strong leadership and a commitment to modernising services for the benefit of patients and local communities;
- have the support of staff and other local stakeholders for their vision for reform.

The applications process for NHS foundation trust status comprises of two distinct phases:

- (i) Department of Health development stage; and
- (ii) Monitor authorisation stage.

Applicants in the DH stage are asked to develop an integrated business plan that sets out:

- the vision for the new organisation in a five year business plan. This must complement the local health community's vision;
- proposals for their governance arrangements (e.g. membership arrangements, size and composition of the board of governors and board of directors etc);
- the proposed human resources policy.

At the end of the development stage, the Secretary of State for Health will consider the proposal against set criteria, alongside evidence of relevant and inclusive consultation. She will then indicate whether she supports the application. More information on the application process is available in the joint DH and Monitor guide *Applying for NHS Foundation Trust Status: Guide for Wave 3 Applications*.

Once the Secretary of State has given her support, applicants will be asked to submit an application for an authorisation to Monitor. The final decision on whether an organisation can be established as an NHS foundation trust rests with Monitor.

Want to know more?

- Ten key points about NHS foundation trusts are set out at Annex A.
- More detailed information is available on all aspects of policy on NHS foundation trusts at:
<http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/SecondaryCare/NHSFoundationTrust/NHSFoundationTrustArticle/fs/en>
- The Health and Social Care (Community Health and Standards) Act 2003 can be found at <http://www.legislation.hmsso.gov.uk/acts/acts2003/20030043.htm>
- Information on the role of Monitor together with the publications can be found at <http://www.monitor-nhsft.gov.uk>
- Applying for NHS Foundation Trust Status: Guide for Wave 3 Applications.
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4124372&chk=ANe7cw

2. Governance – an outline

2.1 What are the proposed governance arrangements for an NHS foundation trust?

NHS foundation trusts will establish stronger connections between local hospitals and their local communities, extending involvement beyond the current consultation arrangements and building on the sense of ownership local people feel for their hospital. Local people, patients and their carers and members of staff will be able to become members of their local NHS foundation trust.

The governance structure for NHS foundation trusts has three main components. These are:

- a **membership community** made up of local people, patients and their carers and staff. It can include people who do not live in the local area if an NHS foundation trust chooses to make them eligible;
- a **board of governors** which will include governors elected from the membership community as well as people appointed from primary care trusts and local authorities. If the NHS foundation trust has a medical or dental school then the board of governors must have at least one University governor. If the NHS foundation trust has designated partner organisations in its constitution then the partner organisations will also have the right to appoint governors. As long as the majority of governors are elected from the public and patient constituencies each NHS foundation trust will have the right to choose how their board of governors is structured.
- 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 NHS foundation trust, appointed by the governors, will chair the board of directors and preside over the board of governors.

A summary of the appointment and removal process for governors and directors is given below in Table 1.

Table 1: Appointment and removal process for governors and directors

	Appointed	Terms of office
Public, staff and (where applicable) patient Governors	Elected by members on a constituency basis	Must be re-elected within 3 years. NHS Foundation trust sets total time a governor may sit on the board.
Other types of governors	NHS foundation trust determines the number of posts and the eligible organisations, subject to the minimum requirements in the Act (see section 4). Eligible organisations are to appoint their representatives, subject to any appointment criteria set out in the constitution of each NHS Foundation trust.	NHS foundation trust decides terms of office.
Chair	Appointed by the board of governors at a general meeting. NB Different procedures may apply for the appointment of the first Chair. See below.	Removed by governors if three quarters of the board of governors agree at a general meeting. The board of governors decide the terms of office, at a general meeting.
Non-executive directors	Appointed by the board of governors at a general meeting. NB Different procedures may apply for the appointment of the first non-executive directors. See below.	Removed by governors if three quarters of the board of governors agree at a general meeting. The board of governors decide the terms of office, at a general meeting.
Chief executive	Appointed by the non-executive directors, subject to approval by the board of governors. NB Different procedures may apply for the appointment of the first chief executive. See below.	Removed by the non-executive directors, the decision is not subject to approval by the board of governors. A committee of non-executive directors is to decide the terms and conditions of office, though the constitution can make provision for these matters to be decided pending establishment of such a committee.
Other executive directors	Appointed by a committee consisting of the chair, chief executive, and other non-executive directors.	Removed by a committee consisting of the chair, chief executive, and other non-executive directors. A committee of non-executive directors is to decide the terms and conditions of office.

Initial appointments to the Board of Directors

The Act provides for different procedures to apply to the appointment of the chair, non-executive directors and chief executive when a NHS foundation trust that was a NHS trust is first authorised. These procedures are aimed at ensuring continuity of the organisation during the transition to the new governance arrangements. They will also mean that before taking on responsibilities for appointments to the board of directors, the board of governors is able to develop in its role as a new board.

Under provisions in schedule 1, paragraph 19 of the Act, the chief executive is appointed as chief executive and the chair and non-executives of the applicant NHS Trust are appointed to the board of directors of the NHS foundation trust. These provisions apply only if, in each case, the person concerned wishes to be appointed. The Chair and non-executive directors will be appointed for the remainder of their term on the NHS Trust board or 12 months, whichever is the longer. Any vacancies on the board of directors that arise during the first year will be filled following the appointment procedures set out in the trust's constitution.

2.2 How will you know the governance arrangements are good ones?

The Department of Health has developed assessment criteria for good governance guided by the advice given to us by the Governance External Reference Group see Applying for NHS Foundation Trust *Status: Guide for Wave 3 Applications*. NHS foundation trusts will need to consider a variety of issues when developing their governance arrangements. Ultimately, these will need to fit within the local context and the specific requirements of a health-focused organisation and applicants will be asked to provide details of their proposals for:

- encouraging genuine community engagement;
- the composition of a board of governors that is balanced and properly representative of socio-economic, racial and geographical differences within the membership community;
- communicating with the membership, including arrangements for election of the board of governors;
- ensuring engagement of all staff throughout the organisation.

Each NHS foundation trust will be expected to tailor the flexibilities available within the legislation so that their governance arrangements are appropriate to their local circumstances. Amongst other things they will need to:

- set out the boundaries of the proposed membership community on application;
- open up access to membership as widely as possible to get involvement from people and groups who are not already engaged. For example through patient support groups, community organisations, faith groups or the League of Friends;
- define the size and composition of the board of governors and the board of directors;
- maintain a register of members, governors and directors;
- set out the processes for holding elections for governors;
- ensure that the governors are able to communicate effectively and involve the members that elected them;
- demonstrate that they have made links to existing and new community based structures such as primary care trust boards, Local Strategic Partnerships and Patients' Forums.

3. Membership

3.1 Legal minimum

The legislation relating to members and membership is set out below.

Constituencies

All NHS foundation trusts must have both at least one public constituency and a staff constituency. Each NHS foundation trust may also have a patient constituency. (Schedule 1, paragraph 3(1)).

The constitution of an NHS foundation trust must specify the minimum number of members of each constituency. If a constituency is sub-divided, the constitution must also specify a minimum number for each class (i.e. sub-division) of the constituency. (Schedule 1, paragraph 5). The trust must ensure that the minimum numbers stated can satisfy the Act in that they can demonstrate that the membership is representative and that credible elections can be held. It is unlikely Secretary of State support will be given unless a reasonable minimum level is used.

Public constituency

Every NHS foundation trust must have one or more public constituencies. The average number of public constituencies per trust is four with a number of trusts having just one public constituency and at the opposite end of the scale the largest number of public constituencies is nine. The area of a public constituency must be defined on the basis of one or more local government electoral areas (schedule 1, paragraph 3(2)). People who live in a public constituency area can become members of that public constituency (schedule 1, paragraph 3(1)(a)). It is not possible to sub-divide any of the public constituencies.

Patient constituency

An NHS foundation trust may also provide for a separate patient constituency. This will include people who have attended one of its hospitals as a patient or carer of a patient within a specified period (schedule 1 paragraph 3(1)(c)). The relevant period must be specified in the constitution. People who are carers because of a contract of employment or their role as a volunteer in a voluntary organisation are not eligible (schedule 1, paragraph 3(5)). The patient constituency may be sub-divided into three or more classes, one of which must be for carers. There are a number of NHS foundation trusts who have chosen not to have a patient constituency and only two out of the current wave 1 NHS foundation trusts have sub-divided this constituency.

Representative membership

NHS foundation trusts must take steps to secure that the membership of the public constituency (or constituencies) and the patient constituency (if there is one) is representative of those eligible for membership (section 6 (2)(b)). Monitor may specify requirements in the terms of authorisation to secure this (section 37) and each NHS foundation trust's annual report must include information on what steps they have actually taken to secure a representative membership (schedule 1, paragraph 26(2)(a)).

Staff constituency

Employees of the NHS foundation trust can be members of the staff constituency (schedule 1, paragraph 3(1)(b)). To be a member of the staff constituency, staff must either have a contract of employment that does not have a fixed term or have a contract of employment with a fixed term of at least 12 months, or have been employed continuously for 12 months (schedule 1, paragraph 3(3)).

If the NHS foundation trust so chooses, members can include people who have exercised functions for the purposes of the NHS foundation trust but are not employed by the NHS foundation trust itself. Such individuals might potentially include volunteers, academic staff or nurses and doctors who are employed by a recruitment agency. To be eligible for membership they must have exercised functions for the purposes of the NHS foundation trust for at least a year (schedule 1, paragraph 3(3)(b)).

The staff constituency may be sub-divided into two or more classes. The average number of classes is three with a number of NHS foundation trusts deciding not to sub-divide this class while the highest number of classes is six.

Rights and responsibilities

Anyone eligible for membership of the staff constituency cannot be a member of a public constituency or patient constituency (schedule 1, paragraph 4(6)).

The constitution may make further reasonable provision as to the circumstances in which a person may not be a member (schedule 1, paragraph 3(7)).

The Act also contains provisions designed to ensure that only individuals who are eligible to vote in elections of the board of governors may do so. In particular, section 36(1) provides that a person may not vote at such an election unless, within a specified period, they have made a declaration on their qualification to vote as a member of the public or patient constituency.

A person is guilty of an offence under this section if they knowingly or recklessly make a declaration that is false and are liable to a fine not exceeding £2,500.

Becoming a member

A person who is eligible to become a member of one of the constituencies of an NHS foundation trust can do so on application to the trust i.e. opt-in membership.(schedule 1, paragraph 6(1)).

If an NHS foundation trust so chooses it can adopt an opt-out system for membership of the staff constituency and patient (but not carer) membership of the patient constituency. Under this system staff or patients become members on invitation by the NHS foundation trust unless they inform the trust that they do not wish to be a member (schedule 1, paragraph 6(2) and 6(3)). Members can only belong to one constituency (schedule 1, paragraph 4(5)) so trusts that adopt an opt-out system must ensure that people invited to be members are not already registered as a member. They must also ensure that staff who have also been patients are not invited to become patient members.

Where NHS foundation trusts adopt an opt-out system for patient membership, they may invite patients who would be eligible to be members of the public constituency to join that constituency rather than the patient constituency. However, patient members recruited this way will still have the option of applying to join the patient constituency instead (schedule 1, paragraph 6(1)).

Retrospective opt-out may create problems under the Data Protection Act - ie personal information being used for purposes for which it was not collected. However, future opt out (ie from this day forth) is much more straight forward, not least because people will provide their details at the same time as they are informed of becoming a member (unless they decide to opt out). For any patient entering a new episode of care being informed of becoming a member under the opt-out process should still be within the Act. This remains the case for patients who have been treated by the NHS foundation trust previously, as their personal information may be checked/amended and they will be informed of their membership in the context of using services.

Only one of the initial twenty NHS foundation trusts chose to opt-out membership for the patient constituency. NHS foundation trusts felt that it was generally better and more cost effective to recruit a committed and active membership and the consensus was that this was more likely to be achieved by using the opt-in system. The exception to this was in creating the staff membership where most trusts used the opt-out method of recruiting members.

3.2 Creating constituencies

Each NHS foundation trust must have members who are individuals drawn from two constituencies: public members from one or more public constituencies in a defined geographical area or areas, and a staff constituency consisting of all the staff members in one or more classes. Trusts may also have a patient constituency consisting of all the patient and carer members in one or more classes. Each constituency or class of members will have the right to elect one or more members to the board of governors and trusts must specify the minimum number of members in each constituency and class in their constitutions. The Department of Health recommends that NHS foundation trusts should seek to recruit an active and engaged membership and should set realistic targets for membership based on the individual circumstances of the organisation. In setting realistic targets the trust should consider the total number of staff, the population resident within the defined geographical area, the method of recruitment and the

membership numbers in comparable trusts. It will be important to demonstrate throughout the application process that the trust is actively recruiting members in line with the targets set. The minimum numbers specified in the trust's constitution should be in line with what is realistic for each individual NHS foundation trust.

Public constituency

Each NHS foundation trust will need to set out the one or more separate constituency areas that it intends to define for its public membership. To do this it must use local government electoral boundaries in England and Wales. The constituency will thus be made up of electoral areas used for defining local government elections (which includes, county councils, district councils and parish councils).

For an NHS foundation trust to receive authorisation from Monitor, taken as a whole the public constituency or constituencies, must be representative of the population served by the trust. This means that it will need to reflect the full diversity of its potential community and be representative of the community served i.e. the local socio-economic, racial and cultural diversity. They will also need to ensure that it is representative in terms of the gender and age split.

NHS foundation trusts need to take into account the needs of a wide variety of populations they may provide services to. For example, if an NHS foundation trust's public constituency includes an area where there is no local hospital, the trust's public membership must still be available to that community. The public may still wish to become members of a NHS foundation trust they may receive services from.

Patient constituency

NHS foundation trusts can also choose to have members who belong to a patient constituency. The patient constituency can include people who have been patients at the Trust's hospitals and their carers within a specified period, regardless of their place of residence. The definition of 'hospitals' in the National Health Service Act 1977 is very broad and includes clinics, dispensaries, and any institution for the reception and treatment of persons suffering from illness. This definition should be sufficient to capture all of the patients of an NHS foundation trust wherever they are treated.

Having a patient constituency ensures that there will be a patient or carer on the board of governors which cannot be guaranteed if there is only a public constituency. However, the majority of public members have a connection with the NHS foundation trust usually as a result of having received treatment and a significant number of public governors either are currently or have been patients. In the first wave of NHS foundation trusts, those applicants whose services were largely secondary care from a district general hospital site tended not to include a patient constituency as they could satisfy themselves that most patients were resident in the public constituencies. The patient constituency was viewed as a method of problem solving:

- by allowing trusts, who provided specialist services and drew patients from outside of their geographical boundaries, to recruit those patients as members. This means that patients from Scotland, Isle of Man and

overseas, excluded from membership of the public constituencies could become members of a patient constituency.

- by creating the opportunity to sub divide the patient constituency into classes it is possible to ensure representation on the board of governors of a particular patient or age group. For example, if the patient constituency is sub divided into three age groups and a carer's group then a member of each of those age groups plus a carer will be elected to the board of governors.

This particular issue was the subject of a great deal of debate within the mental health trusts in wave 2. On the one hand was the genuine desire to ensure that service users and their carers were elected as governors and so represented on the board of governors and on the other hand was the dilemma of dealing with the potential stigma of being a member of a patient constituency.

It is for each NHS foundation trust to decide whether to include a separate patient category in their membership and how they define the eligibility period that applies. This means that patients can be members of a NHS foundation trust even if they do not live in the geographical area defined as its 'public constituency'. To ensure that its members have a meaningful connection with the organisation, trusts may decide, for example, to limit eligibility to join the patient constituency to people who have been treated in a 2-5 year period before an election. In deciding what the period should be, trusts will need to consider factors such as the requirement to keep an accurate register of members' addresses for election purposes and the additional maintenance costs associated with defining a set period of a number of years. Some NHS foundation trusts have chosen to include all patients treated since the inception of the NHS in 1948. This reduces the costs of on-going reviews of the database to ensure that members continue to meet the eligibility criteria but could prove difficult to manage if the trust chose to use an opt-out system for recruiting patient members.

The patient constituency may be divided into three or more classes as defined in a trust's constitution. Where the patient constituency is divided into classes in this way there must always be a separate class for carers, and trusts must ensure that everyone eligible to be a patient member is included in one of the classes.

The **Bradford Teaching Hospitals NHS Foundation Trust** serves the half million population of the Bradford Metropolitan District Council with around 92% of income coming from the Bradford PCTs. The remainder comes from out-of-Bradford PCTs covering other parts of West Yorkshire, North Yorkshire, East Lancashire and North Trent. The trust has made the out-of-Bradford areas the patient constituency and has two governors from those areas, elected by former and current patients and their carers

The **Peterborough and Stamford Hospitals NHS Foundation Trust** decided not to have a patients constituency as the vast majority of its patients come from a clearly defined geographical area which was used to comprise the public constituencies.

The **Papworth Hospital NHS Foundation Trust** provides services to a core catchment of 3 million people in Norfolk, Suffolk, Cambridgeshire, Mid and North Bedfordshire and surrounding areas, but receives referrals for certain sub-specialties from throughout the UK. The trust has created six public constituencies including a Rest of England constituency to accommodate those wishing to join who live outside the immediate geographical area.

Staff constituency

Each NHS foundation trust will need to set out the criteria for definition of its staff constituency.

They must include staff of the NHS foundation trust who:

- are employed by an NHS foundation trust under a contract with no fixed term;
- are employed by the trust under a contract with a term of at least 12 months or more; or
- have been continuously employed with the trust for 12 months or more. This will include individuals who have been employed by the trust on a series of short term contracts amounting to a year or more. Continuous employment should be determined in line with chapter 1, part 14 of the Employment Rights Act 1996.

An NHS foundation trust may also extend staff membership to include individuals who are not employees of the trust but who still exercise functions for the purpose of the trust for 12 months or longer. Such individuals may include:

- individuals who are employed through recruitment agencies;
- volunteers where they are exercising functions for the purpose of the trust;
- staff employed at an NHS foundation trust through an independent contractor. An example would be the provision of catering services by an outside agency.

Trusts may divide the staff constituency into separate classes. This can be done in various ways provided the basis for subdivision is set out clearly in the constitution. Trusts may decide to use accepted professional distinctions in drawing up the sub-divisions, eg:

- (a) medical and dental practitioners;
- (b) other clinical staff not in (a);
- (c) all other staff not in (a) or (b).

This could be expanded to bring out other key groups such as AHPs, ancillary staff, admin and clerical, managers etc. An alternative approach would be to either define separate sections to cover different hospital sites or to divide into specialities. Whatever approach a trust uses it will need to ensure that the definitions used cover everyone who is eligible to be a staff member.

3.3 Who can become a member?

People can be members of more than one NHS foundation trust if they meet the membership eligibility criteria. Each NHS foundation trust must include criteria in its constitution about who can become a member. Members must be individuals so an NHS foundation trust cannot have corporate members. There was a great deal of concern amongst the wave 1 applicants that membership would be dominated by single issue groups however, there is no evidence to date that this has happened.

Members are only entitled to a single vote in elections to the board of governors. This means that even though some people may be eligible to join in more than one category they can only join one constituency or one class of a constituency that is subdivided. In addition, to avoid potential conflicts of interest, people who are eligible to join the staff constituency are excluded from membership of the public and patient constituencies. An NHS foundation trust may also specify in its constitution other reasonable exclusions as to why a person may not become a member. Trusts will need to ensure that potential members can find out what the membership options are.

Public members

- It will be for each NHS foundation trust to decide who can be a public member based on the definition of the geographical area covered by its public constituency or constituencies. The Act does not exclude children from membership but trusts may wish to include minimum age limits in their constitutions.

After considering the guidance around competence in the children's national service framework, **Moorfields Eye Hospital NHS Foundation trust** decided on a lower age limit for membership of 14 years. The trust wanted to include children as many of its patients start when very young and stay with the Trust through to adulthood. Their experiences and those of their parents/carers are important to the Trust. Children under 14 may be represented by their parents/carers.

- MPs and members of the House of Lords can become members if they live in the area defined as the public constituency. NHS and other public sector employees can also be public members if they are not eligible for staff membership.
- Within the constitution some NHS foundation trusts have sought to ensure that members uphold the values of the trust by including the following exclusions:
 - anyone who does not agree to abide by the Trust principles;
 - anyone who has been involved in any act of violence against staff or other members of the trust;
 - anyone who has been identified as a vexatious complainant.

Patient members

The Act includes a broad definition of eligibility for patient membership based on attendance at one of the trust's hospitals within the period defined in the trust's constitution. NHS patients from other parts of the UK, overseas patients and people who attend for private rather than NHS treatment are included in this definition and would therefore be able to *apply* for membership of the patient constituency if there is one. If an NHS foundation trust chooses to use an opt-out approach for patient membership it could limit *invitations* to certain classes of patients, e.g. to the exclusion of private or A&E patients, but would have to make provision for membership on application from other eligible patients and carers.

3.4 What can members do?

Membership of an NHS foundation trust is participation and real responsibility – where local people get involved in the running of their local services not for personal gain but for the benefit of the local community. Members of an NHS foundation trust:

- may vote at an election of the board of governors provided they have, within a specified period, made a declaration in the specified form stating the details of their eligibility to vote as a member of the public constituency or (as the case may be) patient constituency. The form of the declaration must be written into the NHS foundation trust's constitution;
- can stand for election to the board of governors;
- will receive care and treatment at any hospital on exactly the same basis as any other NHS patients whether they are a member or not;
- may be asked their views by the trust's governors.

In addition, members of the public and patient constituencies are eligible for appointment as non-executive directors, including as Chair of the trust providing that they fulfil the criteria as defined by the board of directors.

3.5 Why have members?

Experience from other sectors and research evidence shows that the benefits of having members are considerable and two-way. Research shows that:

- people tend to get personal satisfaction and skills from engaging in public services and mutual organisations. In general, people who participate in the public sector are not motivated by personal benefits. Research shows that they want to achieve tangible material benefits for the people they represent and the higher the level of participation the more they achieve,

2.5 million people donate blood at least once a year to support a service that 99% of them will never need to benefit from.

- participation in an organisation can bring benefits to the organisation and its stakeholders other than financial reward. People with a stake in an

organisation can identify with it more readily and this provides organisations the opportunity to become more responsive and through that create more effective services, experience increasing loyalty and staff retention. It increases their understanding of the organisation and with that comes greater trust. Examples below show how other organisations have used their memberships to feed service developments and improvements and how engaging with users brings service improvements;

At the **Britannia Building Society's Member Panel** issues such as improving service at the call centre, keeping members better informed of interest rates changes and changing the opening hours of some branches to better meet local needs have all been raised. Action has been taken as a result of the feedback that is then communicated back to members.

In the last year the **Nationwide Building Society** has had more than 150,000 items of feedback direct from members. This has led to at least 200 service improvements that can be traced back to that feedback – and an 18.7 per cent reduction in complaints.

In 2002 the **Newcastle-Upon-Tyne Hospitals NHS Trust** created a Community Advisory Forum. The 12 person forum covered the whole of spectrum of socio-demography of the local population and included a mix of both genders, professions, and ethnic diversity. The forum have increased the public representation on the research committee and have checked the phraseology of the Trust's public documents and contributed to the re-design of waiting areas.

Forum members receive free car parking for meetings and are reimbursed for child care and adult care but are not paid for their work.

There is evidence from research and experience in the US and here that people who live with longstanding illness need not just be recipients of care, but can make decisions about their own treatment and gain greater control over their lives. Their own knowledge of their condition can be developed so that they gain the confidence and motivation to take some responsibility for managing their daily lives and working in partnership with the health professionals that treat them.

It was this evidence that influenced the Government's decision to initiate the **Expert Patients Programme** – the world's first nationally-based self-management training programme. This programme is being introduced in primary care trusts around the country. Early results from the pilot courses are extremely encouraging – there have been some very positive accounts from people who have attended courses about how the new skills they've learnt have helped them gain more control over how they live their lives.

- staff feel that they have a productive personal stake in the organisation. In turn this enhances communication between the management team and staff and between staff and their patients and changes the relationship between the organisation and the people who use it to one in which members are an integral part of the organisational fabric. Staff are more likely to be better

motivated, more efficient and less inclined to leave – and that is critical to successful service delivery;

At the **John Lewis Partnership**, employees elect 85% of a Central Council which itself elects members to a Central board which is responsible for commercial activity. This provides a direct link between proposals for service improvement and those needed to bring it about (ie staff) and research has shown employees welcome their ability to change things on the shop floor and are more enthusiastic about that change.

Leeds Mental Health Teaching NHS Trust have developed a Framework of Personal Responsibility. It seeks to involve each member of staff in contributing to the standards of care offered and empower each person to continuously improve individual or team performance by taking personal responsibility for their actions/standards of work.

Hinchingbrooke Healthcare NHS Trust designed a series of events to engage staff in the work needed to improve. Staff views have been sought at all levels on how the organisation needed to change and how this change could be implemented. Staff were asked to attend a series of events and a staff attitude survey was conducted to help the process. The subsequent feedback identified where the organisation was, and is being used to seek further views on how the organisation moves forward.

Greenwich Leisure is a multi-million pound enterprise with charitable status. It has over 1000 full time staff and a governance structure that gives employees, unions, customers and local councillors a genuine say in how the business is run.

“Because we are a genuinely staff led company, staff are both the employers and the owners. This creates a virtuous loop of empowerment that is very powerful. They own the outputs and they own the inputs – it means they can’t just blame somebody else when things don’t work, but at the same time they can directly affect the way we do things” says CE, Mark Sesnan.

Greenwich Leisure’s democratic heart lies with its governing board. Made up of members elected by their peers, it contains 12 staff, two leisure centre users, three councillors and a trade union representative. The board sets the strategic direction for the business and holds the executive directors to account for day to day operations.

“We’re now in a position to say ‘if it’s the right thing to do, let’s do it’. If things go wrong, then we have to find a way to manage ourselves out of it, but it doesn’t stop us trying to do the right thing.”

Governors are also taught the importance of collective responsibility and the need to put personal interests to one side when making organisational decisions. Sesnan says: *“The real evidence of success is that people regularly vote for our services as being the best around. We’re actually doing what our customers want us to do. it’s not rocket science. Our main achievement has been releasing the energies our staff have and letting them take control of their future.”*

In 2005 the Healthcare Commission carried out a review of the first 20 NHS foundation trusts. Although they reported that it was too early to assess fully the benefits of having a membership there were examples of where members had started to make a contribution, including:

- increased attendance at annual general meetings;
- actively recruiting patients from the membership lists into initiatives to improve services;
- offering advice on improving the environment, such as access to the hospital, car parking and signage;
- participating in reviews of services such as improving services for outpatients and children;
- increased participation in fund raising events for the hospital;
- actively recruiting members for the NHS foundation trust.

Want to know more?

Sources of information for the examples given above are:

- The Bradford Teaching Hospitals NHS Foundation trust website can be found at www.bradfordhospitals.nhs.uk.
- The Moorfields Eye Hospital NHS Foundation trust website can be found at www.moorfields.org.uk.
- *A fuller account of potential patient benefits can be found at Herzlinger R (1996) "Can Public Trust in Non-Profits and Governments be Restored?" Harvard Business Review, March-April 1996.*
- The Britannia Building Society can be contacted via website at www.bsa.org.uk for further details of member panels.
- The Nationwide Building Society can be contacted for further details of the benefits of memberships. Their details can be found at www.nationwide.co.uk
- Details of the Community Advisory Forum can be obtained from Newcastle Hospitals at www.newcastle-hospitals.org.uk
- Further information on expert patient programmes can be found at www.4ps.com and at www.ohn.gov.uk/ohn/people/expert.htm
- The contact details for the blood donor service can be found at www.blood.co.uk
- Details of the staff Central Councils can be obtained from John Lewis plc at www.johnlewisjobs.com
- Further details on Greenwich Leisure can be found at www.employee-ownership.org.uk
- "New voices and new accountabilities" published by the Foundation trust Network
- Further details on the Healthcare Commission review can be found at www.healthcarecommission.org.uk

Other useful research evidence can be found at:

- Birchall J and Simmons R (2001) "Member participation in mutuals; a theoretical model" in Birchall (ed) *The New Mutualism in Public Policy*, London, Routledge.
- Hudson M, *Managing without profit. The art of Managing Third Sector Organisations* (directory of Social Change 2002 www.dsc.org.uk).
- Richard Lewis "Governing Foundation trusts: a new era for public accountability", Kings Fund, May 2005
- Joseph Rowntree Foundation (1999) *Developing Effective Community Involvement Strategies*, Ref 169 www.jrf.org.uk/knowledge/findings/foundations/169.asp.

3.6 Developing a membership - areas to consider

As part of the application process NHS foundation trusts will need to provide details of proposals for creating and maintaining their membership constituencies. They need to address how they will:

- seek to make the membership genuinely representative of the community served;
- ensure that all staff groups are given an equal opportunity to participate;
- give assurance that the proposals allow for and encourage a continuing dialogue between governors and members over and above the legal minimum;
- maintain and grow their membership community once the NHS Foundation trust is established;
- demonstrate that they will be proactive in increasing numbers and developing interest in membership;
- ensure that members receive regular information about the NHS Foundation trust in, for example, newsletters and the annual report and accounts;
- involve and consult members, for example, on matters relating to how provision of NHS clinical services by the NHS Foundation trust can be improved.

Roberts Bell Associates explored the understanding by the general public of accountability through a series of focus groups for a piece of work on *Involving the Public* undertaken by the Local Government Management Board. They found that the concept is much wider than just voting someone out in elections. They concluded that the following were all-important in public involvement: being accessible; being responsive; taking responsibility; taking ownership of problems; keeping people informed; listening to people and being open and honest.

Experience from membership organisations in other sectors suggests that in developing membership communities you need to:

- beware of being too narrow. The better the dialogue with members the better members will understand what the NHS foundation trust is trying to achieve;

The NHS has numerous examples of designing new buildings and hospitals and then asking the public to choose the décor and the curtains but only once 90% of the core fabric of the building has been agreed by professionals and clinicians. This kind of behaviour can create resentment amongst the local community – the very people for whom the services are being developed.

- remember that members can work together, which may increase their ability to affect the organisation;
- don't shy away from hostile people;

Camelot chose panel members for their stakeholder council carefully to include representatives who were opposed to the 'for profit' format of the lottery as well as those from more supportive organisations.

- recognise different groups have different reasons for becoming members. Consider doing market research to identify your member groups. When you consult this will help you analyse the responses;

Extracts from surveys of why people have become NHS foundation trust members revealed the following reasons:

- an interest in the work of hospital;
- a desire to be involved in Hospital;
- wanted to have a say in treatment;
- an ex member of staff who wanted to keep in touch;
- a desire to keep abreast of new developments;
- felt a sense of loyalty to the Hospital after receiving treatment;
- wanted to support a worthwhile local service;
- because they were asked.

Calderdale and Huddersfield NHS Trust distributed 40,000 questionnaires to staff and members of the public throughout their local community to seek their views on what people expect from becoming a member of an NHS Foundation trust.

- be aware that public service users' commitment builds up over time but it only stays if the experience is positive. Experience shows that it is easy to lose touch with members and for them not to understand what being a member really means;
- be clear about which issues will not be the subject of member or public engagement. For example, many local authorities choose not to involve the public on issues that are confidential, 'internal management issues' or commercially sensitive.
- try to create realistic expectations among members and the public of the likely outcome of being a member. Members will lose interest if they perceive few results from their commitment of time and effort;
- A number of NHS foundation trusts ask members to define the level of commitment that they wish to make. Some members are content to elect a representative and then keep in touch with the hospital through a newsletter. Others are prepared to commit a substantial amount of time and they may put themselves forward to become governors or join forums. By recording this

information on the member's database NHS foundation trusts can tailor their communication and level of engagement to the needs of individual members.

Want to know more?

Sources of information for the examples given above include;

- www.lgmb.co.uk gives further details of the Roberts Bell Associates work on Involving the Public.
- Details of the advice given to schools can be found at www.dfes.gov.uk
- www.huddweb.demon.co.uk gives the contact details for Calderdale and Huddersfield NHS Trust.

3.7 Creating a membership

Advice from membership organisations includes:

- check what mechanisms the trust already has to engage with patients and look at ways to use this to create your membership. There may be several small initiatives already in place, which have never been effectively mapped to show areas of duplication or gaps in provision - for example, leaflet reading groups, roles performed by volunteers, patient satisfaction studies, support groups facilitated by staff, liaison with local patient forums.

Moorfields Eye Hospital NHS Foundation Trust send all new patients a membership leaflet with their first appointment letter. The Trust is looking into the opportunities presented through combining the PALS prospectus together with membership information and registration.

Bradford Teaching Hospitals NHS Foundation Trust has made extensive use of the Local Authority's Area Panels and Local Neighbourhood Forum structure. Bradford is divided into 5 areas that map to the 5 parliamentary constituencies with approximately 100,000 population in each area. These areas are further sub-divided into Local Neighbourhood Forums with anywhere between 10 and 15 forums in each area. The Forums have extensive mailing lists with regular mailshots. They hold regular meetings and the Trust attended more than 70 Forums during its consultation on becoming an NHS Foundation trust. The Trust also made use of the mailshots.

- be proactive. Successful local ownership and accountability comes from creating a wide and diverse membership base;

South Essex Partnership NHS Trust is making use of all existing forums and links with the community - with service users, carers, partner organisations, community and voluntary sectors and staff networks. The Communications and Patient and Public Involvement teams at the Trust are leading on this work. They also plan to link with their partner organisations and stakeholders (NHS, local authorities, schools and voluntary groups) and use their communication channels to attract new members.

- think about where meetings are held. People are more likely to attend meetings if Trusts go to them, but that is still no guarantee. Consider holding them in territory familiar to potential members, rather than in a formal setting or one that's convenient for you. Some members of the community may be reluctant to speak in large groups, for example younger women. They may raise points more informally after the meeting, or prefer one-to-one discussions or women-only meetings. To find out the best approach ask those with whom you wish to communicate with - don't make assumptions about their needs;

- recognise that it's going to take time and effort to develop and maintain your membership base. An NHS trust can only establish the membership of the NHS foundation trust when it has had its application approved by the Secretary of State and made an application to Monitor for authorisation. Many trusts have found that during the preparatory phase, a great deal of time and effort is spent engaging with stakeholders and the public and this provides an ideal opportunity for recruiting members. During this phase trusts can either collect expressions of interest which are then converted after the trust has received approval from the Secretary of State or create a membership of the NHS trust which then automatically becomes the membership of the NHS foundation trust upon authorisation by Monitor.

Lincoln Co-operative Society has a dedicated membership budget that works out at a little under £1.50 per member.

- people respond to personal invitations. The two most successful methods of recruitment are direct mail campaigns usually including a personal letter and on-site face to face recruitment. Staff can play a crucial role in the recruitment of members, front line staff are in constant contact with the public and are in a good position to promote the benefits of membership if they have been properly briefed. Once a membership base has been established Member get Member campaigns have also proved a very cost effective recruitment method.

Before embarking on any direct mailing campaign it is important to check the database for deceased persons to minimise the possibility of contacting someone who has recently died. This is particularly important when using information from the hospital's database as it is very distressing for relatives to receive a letter addressed to a patient who has died at the hospital. Consider carefully the impact of using envelopes franked with the trust's logo as they may cause a great deal of anxiety to ordinary members of the public.

Mailings do generate a number of telephone calls to the trust and it is important to factor this into resource planning for any mailing campaign.

- Many trusts chose to use the data from their PAS to mail out to patients as part of their membership recruitment strategy. The legal advice given to an applicant in Wave 1 was that this was acceptable provided that patients are informed that their details have been obtained from that source, that the information will remain confidential and will not enter the public domain other than their names being on the member register unless they request that they are excluded.

However not all applicant situations are the same and trusts should use their own judgement on the approach they take. If there are any doubts about the use of patient data the trust you should contact the Information Commissioner to clarify the particular circumstances;

- make sure that any material can easily be understood. Procedures should be clear and free from jargon;

Kings College Hospital has a trust policy on how to write materials that will be appropriate to the public. Many trusts now engage members of the public via reading groups to check the legibility and clarity of documents and standard letters produced by the trust.

- try to get invited to events that people are regularly attending, and where you are regarded as a guest and therefore people feel secure and confident to speak freely;

Mother and toddler groups are a great way to engage young women to give their views on women's health care services or child care services. The WI have been very receptive to speakers. **Asian women** often meet communally to undertake various activities such as cooking or clothes making. It is easy to sit in on such activities without obstructing the activity or dominating the proceedings. This makes engagement a normal social interaction rather than a false, stage managed affair.

- think about using electronic or telephone techniques to supplement more traditional methods such as questionnaires and surveys, public meetings and mail shots. For instance texting may be a better way of communicating with teenagers, touch screen information points are useful in areas where people have to wait, internet based discussion boards can also be used to reach people and give them more context than traditional methods;
- think about using unusual means of connecting with the membership. For instance, local art and drama groups can be used to develop issues on a thematic basis. They are particularly useful for showing both staff and patients how they are perceived from the other's perspective;

The **Garnett Foundation** states that its mission is to harness the diversity, energy and creativity of people toward the common purpose. They achieve this by finding imaginative and cost-effective ways of helping people learn, develop and adopt positive behaviour at work. Their ethos is to provide practical and creative solutions to organisational issues and challenges, particularly in the areas of leadership, communication and the management of change.

One of the processes they use is the Forum Theatre. Professional actors are used to create scenarios which the audience then direct to a conclusion. For example, there could be a patient, a receptionist, and a GP, each of whom are directed by a separate third of the audience. The actors understand how to create stereotypical problems within a general practice setting that the audience then actively seek to resolve. This method of participation works equally well with professionals and the public alike.

- acknowledge that some elements of society have low expectations of services and express few criticisms. Some people are also reluctant to complain in hospitals – they feel they may be victimised and given poor treatment. For instance it may be important to ask the same questions of the same people in different settings – the answers may be different.

The Discovery Interviews programme undertaken by the **Coronary Heart Disease collaborative** of the Modernisation Agency realised very early in their work that people responded differently in hospital than they did in a more neutral venue. As a result of this, it is now recognised good practice to undertake discovery interviews in the person's own home where they feel most able to speak freely.

- address the fact that the public may like to be involved but don't know how to;

Researchers at the **Leicester Royal Infirmary** did not find it particularly difficult to get people involved once they had made contact with community groups. One elderly Sikh man commented: "I have been here since 1939 and this is the first time anyone has ever come to see us."

- be sensitive to the needs of different ethnic groups – by developing an ongoing dialogue with community leaders you can avoid festival or holy days in different communities' calendars, and to consider which are the most appropriate times of day for people to give their time;

The **Bradford Teaching Hospitals NHS Foundation Trust** has developed a cultural holiday calendar that both informs about and raises awareness of key religious dates and festivals.

- consider translation and interpretation needs;

For instance, many elderly Chinese people do not speak English and around 70 per cent cannot read their own language, so written communication is often inappropriate.

- have information available in appropriate and accessible formats;

For example on audio-tapes or in large print for the partially sighted and the blind. The **Royal National Institute for the Blind** transcription centre provides both advice on and assistance with making information accessible.

At the **Leicester Royal Infirmary** they found that black and minority ethnic organisations stressed people would be more likely to contribute if they could speak – rather than write – about their experiences in their own language. In recent years, many black and ethnic minority groups have been encouraging NHS trusts to invest in teaching local people to act as community interpreters rather than spending large amounts of money on producing written materials in many languages.

- consider how you will reach different groups and ensure contributions are valued. For instance young people may be eligible to become members of NHS foundation trusts. It is important for trusts to overcome barriers to developing a dialogue with them. The whole community can benefit from involving young people: participation opportunities promote citizenship and help young people become more confident and resilient. Children and young people must be treated honestly and seriously. Their expectations need to be managed and they must be helped to understand any practical, legal or political boundaries of their involvement. They must not be prevented from participating effectively on grounds of race, religion, culture, disability, age, ethnic origin, language or the area in which they live.

In **County Durham and Darlington**, a partnership of statutory organisations have come together to create a new way of thinking about what services children, young people and their families need to have happy and fulfilled lives, and how these services are planned and delivered.

Their aim is to work in partnership with children and young people to promote their best interests and enhance their quality of life. This will be achieved by:

- Consulting children, young people and their families about decisions affecting their lives and the development of services;
- Promoting partnerships between individuals and agencies to address young people's issues;
- Developing accessible children and young people and family centred services that promote dignity and independence and which do not discriminate or stigmatise;
- Ensuring that, when decisions are made on policies and services, consideration is given to their potential impact on the lives of children and young people.

All of the Investing in Children Partners have signed up to this. In particular, they have agreed that:

- Adults don't always know best and can listen to and learn from what children and young people have to say;
- Different organisations must be prepared to work together to do what's best;
- Organisations need to break down professional and political barriers.

Nottingham City Hospital employs a youth worker specifically to try to normalise the child's stay in hospital and to also develop a forum in which children feel free to comment on the hospital and the care they receive. Donna Hilton, the youth worker, has developed a youth club within the hospital which is open to all current and previous patients and their siblings. The youth club provides an environment where they can safely take part in activities that are tailored to their needs and restrictions imposed by their illness. The youth club was designed, and is managed, by the children themselves and achieves higher attendance figures than mainstream facilities elsewhere in the City.

- There are a number of professional companies who can assist Trusts in developing their recruitment strategies however this can be an expensive way to recruit.

Want to know more?

Sources of information for the examples given above include;

- RNID (formally The Royal National Institute for the Deaf people) www.rnid.org.uk provides details of their membership.
- Lincoln Co-operative Society website can be found at www.lincolncoop.co.uk
- Kings College Hospital website can be found at www.kcl.ac.uk
- Further details of the scrap metal soul can be found at www.communityarts.net/readingroom/archive/35drumsticks.php - 17k - 29 Jun 2003.
- More information on the Garnett Foundation can be found at: Info@thegarnettfoundation.com
- www.modern.nhs.uk – a guide to using Discovery Interviews to improve care are available from NHS Responseline tel: 08701 555 455.
- The Leicester Royal Infirmary has explored a number of membership areas and can be contacted on www.uhl-r.nhs.uk/services/corporate/corporate_services.htm
- The Bradford Teaching Hospitals NHS Foundation trust website can be found at www.bradfordhospitals.nhs.uk
- The Royal National Institute for the Blind transcription centre (<http://www.rnib.org.uk/services/bra.htm>) provides both advice on and assistance with making information accessible.
- Some examples of the kinds of work undertaken by Investing in Children can be found on: <http://www.family-learning.org.uk/durhamcc/usp.nsf/pws/investing+in+children+-+iic+-+home+page>.

Further useful research evidence can be found at:

- Commission for Patient and Public Involvement in Health (CPPIH) www.cppih.org
- The Department of Health's guidance: Strengthening Accountability: Involving Patients and the Public-Policy and Practice Guidance for Section 11 of the Health and Social Care Act 2001 (www.doh.gov.uk/involvingpatients/invol-pat.htm) has a number of different approaches that can be used when dealing with traditionally hard to reach groups.
- The Improvement and Development Agency (www.idea.gov.uk) identifies more than 100 ways of engaging with the public, and gives a summary of the advantages, disadvantages and likely costs of each.

- The New Economics Foundation has drawn on its experience from around the world to create a handbook of proven participation techniques – *Participation Works* – www.neweconomics.org
- The Cabinet Office has put out guidance on good practice on consultation by government departments. Many principles will apply here www.cabinet-office.gov.uk/servicefirst/2000/consult/code/ConsultationCode.htm.
- Communication and consultation: Exploring ways for staff to involve people with dementia in developing services by Kate Allan is published for the Joseph Rowntree Foundation by The Policy Press and available from Marston Book Services, PO Box 269, Abingdon, Oxon OX14 4YN (01235 465500), price £16.95 plus £2.50 p&p. A summary of the findings is available on <http://www.jrf.org.uk/pressroom/releases/160501.asp>.
- Kretzmann, John and John McKnight. Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets. Institute for Policy Research, Northwestern University (1993).

Ensuring a representative membership

Trusts will only be authorised if Monitor is satisfied that they meet the requirements of the Act in that 'the applicant has taken steps to secure that (taken as a whole) the actual membership of any public constituency, and (if there is one) of the patients' constituency, will be representative of those eligible for such membership. Monitor's compliance regime is designed to ensure that NHS foundation trusts maintain a representative membership.

In order to establish what is meant by representative it is important that trusts establish the profile of the population in their catchment areas. This analysis by age, gender, ethnicity and socio-economic status will enable targets to be set and progress monitored. It is important that NHS foundation trusts collect this data from members and there are a number of software programmes available which will facilitate the monitoring of the data. The experience to date is that the membership tends to mirror the patient profile rather than being representative of the population served by the trust. This is to be expected when most recruitment strategies rely heavily on targeting the patient population of the trust and when the response to any general campaign is most likely to come from the white, middle aged, middle class group.

Achieving a truly representative membership will mean including initiatives specifically designed to reach those less likely to respond to general recruitment tactics. Many NHS foundation trusts feel that they lack the capability to address imbalances in their membership and look to external agencies to provide expertise. This may involve working with the ethnic communities to generate interest by raising awareness of illnesses that specifically affect them. Alternatively areas that are known to have high ethnic populations are targeted for a postal or face-to-face campaign.

Homerton University Hospital Foundation Trust had over a number of years developed strong links with their ethnic communities through the community leaders. These links provided a conduit into the communities and enabled them to recruit members and governors to build a representative membership. As with many NHS foundation trusts the governors themselves are now leading the recruitment of new members.

Engaging young people is another challenge faced by NHS foundation trusts and a number of strategies have emerged to encourage young people to join:

- setting up a young people's sub-group to advise on the most effective ways of engaging with young people;
- working with the local youth parliament;
- establishing local colleges as partnership organisations and working with them to raise awareness of NHS foundation trusts amongst the students;
- targeting the local schools and making presentations to the pupils about the issues that might affect them. This has been particularly successful for mental health trusts who have led a number of sessions on drug and substance misuse.

3.8 Continuing the dialogue

NHS foundation trusts will need to consider how to continue a dialogue with their members. It is important that NHS foundation trusts continue to engage members as turn out at elections will be one of the ways in which this is measured and there is some evidence to suggest that there has been less interest generated from members in the second round of elections. Resources are inevitably constrained and Trusts need to develop a cost effective communication strategy.

- create arrangements for members to be kept informed about what is going on to make sure members continue to feel involved;

Most NHS foundation trusts have developed Newsletters to keep members informed. For a majority of members this is sufficient and if the member is happy to receive it by email it can be a very cost effective method of communication. There are often a number of family members sharing a common address and it is important that only one copy of the newsletter is sent to the address. It is also important to allow a forum for members to put forward their ideas and express their opinions.

- Some members are more active and may want to attend the governor meetings or become involved in focus groups, fundraising events and volunteering. Identifying this group of members early on and ensuring that they are able to participate will prevent frustration and loss of interest;
- Members should be invited to events organised by the trust for the general public and the annual general meeting, research open days and fetes all present good opportunities for the Trust and the governors to interact with the members at no additional cost;
- A number of NHS foundation trusts felt that it was important to hold constituency meetings and surgeries to allow the members and governors to interact. This has proved to be less popular with members unless there is a specific issue to be discussed. Health lectures for members incorporating informal networking is a much more successful format;
- Websites are also proving to be good way of communicating with members and a number of sites now have a members only section;
- The compliance regime will ensure that NHS foundation trusts take continual steps to ensure that new members are attracted on an ongoing basis. A number of trusts have created membership committees of the board of governors tasked with addressing this issue. They review the membership strategy on a regular basis and ensure that the membership base is renewed by engaging with the broader community. In some instances the governors themselves are responsible for taking the message out into the community and recruiting members;
- wherever possible, show members how participation has an effect on the organisation and its decisions, resources and services;

- put together a 'welcome pack' for new members (perhaps customised for different groups). Give members the chance to identify areas of particular interest to them – and keep them informed on trust developments in those areas. Some of the databases allow for newsletters to be customised to the interests of individual members;

All members of, for example, the **Lincoln Co-operative Society** and the **Oxford and Swindon Co-operative Society** receive a welcome pack when they join and they can indicate (tick box, freepost) if they want to get involved further through events, communications, special interest groups and so on.

- arrange for members to be taken on a tour of the hospital services. Because of the potential numbers involved this may need to be limited to particular focus groups. This needs to be more than a museum type tour. Explain why services are organised the way they are, where the pressures are, how the trust handles them, how the Trust interacts with other services such as social care. Avoid jargon and recognise that the member will view your (ie their) services from the eyes of a potential user;

Many Trusts already have systems in place that provide pregnant women with the opportunity to tour the labour suite or for children to attend a session before admission. Some of the principles involved in developing those tours can be developed and expanded upon for wider explanation about how the Trust's services can be explained to members.

- give staff training on handling members' questions. Don't forget that staff are members as well;
- keep communications as simple as possible. Most members will not understand health service jargon.

Want to know more?

Sources of information for the examples given above and others useful research evidence can be found at:

- www.lincolncoop.co.uk
- An evaluation of the People Panels can be found on www.cabinet-office.gov.uk/servicefirst/2000/panel/eval/index.htm

4. Board of governors

4.1 Legal minimum

Structure

Every NHS foundation trust must have a board of governors (schedule 1, paragraph 7(1)). The board of governors is to be made up only of people elected by members of the NHS foundation trust, and people appointed under the provisions of Schedule 1 to the Act. NHS foundation trusts have the freedom to structure their board of governors to reflect the individual needs of each organisation. There is wide diversity in the size of boards ranging from the smallest at eighteen to the largest currently at 53. The average is 33.

The board of governors must have:

- elected public governors. It may also have elected patient and carer governors. More than half of the board of governors must be public, patient or carer governors (schedule 1, paragraph 9(1));
- at least three governors elected by members of the staff constituency (schedule 1, paragraph 9(2));
- at least one governor appointed by a primary care trust for which the NHS foundation trust provides goods and services (schedule 1, paragraph 9(3));
- at least one governor appointed by a local authority whose area includes all or part of the NHS foundation trust's public constituency (schedule 1, paragraph 9(4));
- at least one governor appointed by a university, if the NHS foundation trust's hospitals include a university medical or dental school (schedule 1, paragraph 9(5));
- and may have one or more governors appointed by partnership organisations (schedule 1, paragraph 9(6)).

While not a governor themselves, the chairman of the NHS foundation trust will preside at meetings of the board of governors (schedule 1, paragraph 12)

A number of trusts have decided not to use the term "Board of Governors". As there is a need for clarity of roles it was felt that a title which included the use of the word board had the potential to confuse the issue. The alternatives that are used include Member's Council, Council of Members and Council of Governors.

Public, patient, carer and staff governors

Public governors must be members of a public constituency, and are elected by those members. Staff governors must be members of the staff constituency and, if applicable of the relevant class, and are elected by those members. Similarly, if the trust has opted to have patient and/or carer governors, then those governors must be members of and elected by the relevant constituency and class. Members of one constituency or class may not vote at the election of governors from another constituency or class (schedule 1, paragraph 7(4)).

While the detail is left to the individual NHS foundation trust, each trust's constitution must set out how the elections of the board of governors are conducted (schedule 1, paragraph 14(1)(a)) and must comply with any regulations made under section 35 (see section 10 for more detail).

Primary care trust, local authority, university and partnership governors

Each NHS foundation trust must determine how many governors will be appointed for those primary care trusts to which the NHS foundation trust provides goods and services, and specify this in its constitution. The primary care trust governor(s) are appointed by the primary care trusts directly (schedule 1, paragraph 9(3)).

Similarly, each NHS foundation trust must determine how many governors will be appointed from the local authorities that fall wholly or partly within the public constituency of the NHS foundation trust, and specify this in its constitution. Once they have done so, the local authority governors are appointed by the relevant local authorities (schedule 1, paragraph 9(4)).

Where an NHS foundation trust hospitals include a university medical or dental school, a governors must be appointed from that University. The University governors are appointed by the university directly (schedule 1, paragraph 9(5)).

Each NHS foundation trust must determine whether one or more organisations are to be designated as 'partner organisations' in its constitution, thereby allowing the organisation to appoint a governor to the board. Again, such 'partnership' governors are to be appointed directly by the organisation concerned (schedule 1, paragraph 9(6)).

Finally, each NHS foundation trust's constitution is to make provision about the appointment of all such governors to the board (schedule 1, paragraph 14(1) (b)), and their removal from office (schedule 1, paragraph 14(1) (d)).

Terms of office

Public, patient, carer and staff governors may hold office for a period of three years (schedule 1, paragraph 10(1)) and are eligible for re-election at the end of that period (schedule 1, paragraph 10(2)). If they cease to be a member then they cease to be a governor (schedule 1, paragraph 10(3)).

A person cannot be a governor if:

- he has been adjudged bankrupt or his estate has been sequestrated and in either case he has not been discharged (schedule 1, paragraph 8(1)(a));
- he has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it (schedule 1, paragraph 8(1)(b));
- he has within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on him (schedule 1, paragraph 8(1)(c)).

If it chooses, a NHS foundation trust may also include provisions in its constitution about other reasonable circumstances in which a person may not become a governor of the trust (schedule 1, paragraph 14(2)). Most will chose to set an age limit which, may or may not equate to the lower age limit for membership. Other exclusions frequently used are:

- those subject to a sex offenders order;
- anyone who has been involved in any act of violence against staff or a member of the trust;
- anyone who has in the preceding two years been dismissed, other than by reason of redundancy, from any paid employment with a health service body.

In addition, Monitor may specify certain things that the board of governors should or should not do if he has cause for concern. Monitor may remove all or some governors in cases of the NHS foundation trust failing.

(see section 4.8 for the roles and responsibilities)

4.2 Routes to becoming a governor

There are several routes to becoming a governor:

- **Members of the public and patient constituencies can be elected as public or patient/carers governors.** See section 3 for more detail. The public constituency must include members who live in an area defined by the trust and trusts may establish a patient constituency to include people who have been patients of the trust or who have attended as their carers.

Each NHS foundation trust must decide how many public governor posts, and if applicable how many patient and carer governor posts, they create. Each constituency or class has the right to elect at least one representative to the board of governors. They can have as many as they like provided there is a majority of public, patient and carer governors on the board of governors but it is helpful to apply a logical apportionment of governors between the groups. MPs and Lords can become governors but only in their personal capacity as members of the public.

- **Members of the staff constituency can be elected as staff governors.** The staff constituency is described in more detail in section 3. The staff constituency must include staff on a permanent employment contract or an employment contract of a fixed term of 12 months or more. It must also include members of staff who have worked at the trust for more than 12 months and it may include temporary and voluntary staff if they have 'exercised functions for the purpose of the trust' and if the trust has chosen to include this group in their staff constituency. Each NHS foundation trust decides how many staff governor posts they create but there must be at least three staff governors on the board of governors. There is no maximum number of staff governors in an NHS foundation trust, so long as the public, patient and carer governors remain in the majority on the board and the average currently is five. Each class within the staff constituency has the right to elect at least one member to the board of governors.

The **Countess of Chester NHS Foundation Trust** has six staff governors to ensure that all the main staff groups are represented. Three of the governors are nurses or midwives as they make up 56% of all staff.

- **Primary care trust governors.** Each NHS foundation trust will need to decide which primary care trusts are eligible and how many primary care trust governor positions there will be. They must have at least one but they can have more if they choose to. So long as the public governors remain in the majority on the board, there is no maximum number of primary care trust governors for an NHS foundation trust. It will be for the relevant primary care trusts themselves to appoint representatives to the board of governors.
- **Local authority governors.** Each NHS foundation trust will need to define which local authorities are qualifying local authorities and how many local authority governor positions there will be. They must have at least one but they can have more if they choose to. So long as the public governors remain in the majority on the board, there is no maximum number of primary care trust governors for an NHS foundation trust. It will be for the relevant local authorities themselves to appoint representatives to the board of governors.
- **University governors.** Each NHS foundation trust will need to decide which universities are eligible and how many university governor positions there will be. So long as the public governors remain in the majority on

the board, there is no maximum number of university governors for an NHS foundation trust. It will be for the universities themselves to appoint representatives to the board of governors. If an NHS foundation trust does not have a medical or dental school they do not need to have a University governor.

- **Partnership governors.** Each NHS foundation trust may choose to have partnership governors. Each NHS foundation trust will need to decide which partnership organisations are eligible and how many partnership governor positions there will be. It will be for each partnership organisation themselves to appoint representatives to the board of governors. There is no minimum or maximum number of partnership governors an NHS foundation trust, so long as the public governors remain in the majority on the board.

4.3 Size of the board

The trend in governance in organisations of all types is towards smaller boards of twelve or less and this is particularly relevant where the board is responsible for decision making i.e. a board of directors. However, a larger board is often considered appropriate where the main role is advice and representation and many trusts have felt that a larger board is necessary to ensure inclusiveness of the communities represented by the Trust. The average board of governors currently stands at 33. The board of governors for an NHS foundation trust will need to balance size with function and representation.

One of the key determinants of the size of the board of governors is the experience and confidence of the Chair to manage such a group. A Chair with years of experience working with public bodies or large audiences may feel happy to preside over a much larger group than a person who is relatively new to public office. The trust should also take into account in this assessment anyone who may be regularly required to deputise in the absence of the Chair. The trust will need to ensure that, where a skills assessment of the Board has identified this as a weakness, the development programme is tailored to meet this need.

Before any final decision is made the trust should consider where meetings are likely to be held and if it will be possible to accommodate a large number of governors. Governors in the past have expressed concerns where the meeting room is laid out as a lecture theatre making direct eye contact impossible.

Examples of different sizes of boards of governors are given below:

The **Royal Devon and Exeter NHS Foundation Trust** decided it needed a board of 36 governors to ensure that all stakeholder interests were covered. The board comprises of 19 elected public governors divided to represent areas in a way proportional to local PCT commissioning, 5 elected staff governors, 4 governors to represent each of the local PCTs, 5 governors from local authorities, 1 governor from the local medical school and 2 governors from the voluntary sector.

The **Homerton University Hospitals NHS Foundation Trust** took the view that a board of 27 governors was needed, comprising of 14 elected public governors, 6 elected staff governors, 2 governors from the local PCT, 2 governors from separate local authorities, 1 governor from the strategic health authority, one governor from the local medical school and one governor from another local university with which the trust has strong links.

Some NHS foundation trust applicants have expressed a desire towards a larger board of governors but have wanted to see the membership increase and develop their understanding of their roles and responsibilities before achieving the preferred size of the board. This can be done through gradually increasing the number of governors (eg on an annual basis) provided the statutory minimum is met at all times.

The **Basildon and Thurrock NHS Foundation Trust** decided that 53 was the optimum number of its board of governors and that it should build to the full membership of the board in stages over three years:

Group		Year 1 2004/5	Year 2 2005/6	Year 3 2006/7
NHS	Essex Ambulance Service	0	1	1
	Basildon PCT	1	1	1
	Thurrock PCT	1	1	1
	Billericay, Brentwood & Wickford PCT	1	1	1
	Southend PCT	0	0	1
	Castle Point & Rochford PCT	1	1	1
	South Essex Partnership Trust	1	1	1
Partnership Organisations	Anglia Polytechnic University	1	1	1
	Thurrock & Basildon College	1	1	1
Staff	Based at Basildon and other sites excluding Orsett	2	5	8
	Based at Orsett	1	1	1
Local Authority	Thurrock Borough Council	1	1	1
	Basildon District Council	1	1	1
	Essex County Council	1	1	1
	Brentwood District Council	1	1	1
	Thurrock Urban Development Corporation	0	0	1
Voluntary Sector	Thurrock CVS	1	1	1
	Basildon CVS	1	1	1
	Brentwood CVS	1	1	1
Total Representative Governors		17	21	26
Public	Basildon	8	9	11
	Thurrock	6	7	9
	Brentwood	3	4	4
	Rest of Essex	1	2	3
Total Public Governors		18	22	27
Total Number of Governors		35	43	53

4.4 Creating a board of governors

It is important that trusts identify potential governors from the membership community and encourage them to put themselves forward as candidates. Many trusts ask members to identify their interest in becoming a governor on their application form. It is particularly difficult to recruit candidates from the staff constituencies and in recent elections this group had the highest number of uncontested seats. Potential governors are invited to attend sessions where the role of the governor and the election process is explained in more detail. Providing support to fill out the application form can help to ensure a

more representative board and will be particularly important where young people and people with learning disabilities are concerned.

In considering what sort of governors are required, issues to be considered include:

- almost the whole community will have a stake in the success of the NHS foundation trust in one way or another. In deciding the composition of the board of governors this should be borne in mind;
- different stakeholders can offer new or different knowledge, experience and perspective. They all have sufficient interest in the success of the enterprise to be potentially valuable participants;
- the board should represent the socio-economic mix of the local community, paying attention to diversity and ethnicity;
- the elected governors should be representative of their membership. Having separate constituencies for the public membership or dividing the patient and staff constituencies into separate classes may help achieve this aim. (see chapter 3.2);
- particular thought needs to be given in cases where, say, the biggest hospital is not the one most commonly referred to in the community. Small local hospitals might be seen as being on the periphery of the trust's main business but regarded as important community centrepieces where they are located;
- where the majority of referrals come from. If your trust is a specialist trust or a tertiary centre you may receive most of your referrals from consultants in local or regional hospitals. It is important to try to include such feeder trusts into your plans;
- how different governors will affect the organisation. For instance, primary care trust governors will have a different perspective to those who are affected by the organisation (for example, patients and staff);
- considering letting a group of partner organisations, such as a number of commissioning primary care trusts, nominate one person to represent their interests as a whole. The role of such a representative would not be to represent their specific primary care trust but to ensure that the health economy as a whole is best served and to offer a wide health perspective;
- the board of governors also 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;
- most people given information, training and support, can be effective in decision-making;

Puget Sound Health Group, in Seattle, US has a successful tradition of member participation. Group members receive care from the health care system, but also help guide it. In addition to voting in annual elections, members serve on advisory councils, the board of Trustees, and board committees.

All members can attend Group Health's annual membership meeting, and those who are eligible may vote to elect the board of trustees and on bylaws changes. All Group Health members who are 18 years or older may register to become voting members. Voting members are responsible for electing the board of Trustees, the governing body that votes on all major policy decisions.

Board meetings begin with an open microphone session during which any Group Health consumer can address the board directly on all matters except those related to personal health care. For information about upcoming meetings, members can call a free board of Trustees' newsline.

A Senior Caucus advocates for seniors' needs; works on care delivery, health care coverage, and legislative issues; and plans local meetings with health-related programs. The Senior Caucus has local chapters throughout the Puget Sound area.

Volunteer members participate in groups that make recommendations to Group Health management, medical staff, and the board of Trustees. Member advisory groups include medical centre councils, district advisory groups and network services district advisory groups

- a trust might choose to appoint advisors to the board of governors to assist them. The 'advisors' could not be designated as governors and could not have voting rights but they could be used to bring in missing skills to the board, widen the pool of experience, or ensure the board reflects the diversity of its constituent groups. It may also provide a mechanism to train other board members to ensure that they are able to participate appropriately in decision-making, whatever their background or skills base;

Royal National Institute of the Blind have six co-opted members on their board. An initial skills audit identifies gaps in respect of skills, experience and background and then advertisements are placed and brokerage used to identify appropriate candidates.

Want to know more?

Sources of information for the examples given above and others useful research evidence can be found at:

- The Countess of Chester NHS Foundation Trust website is at www.coch.org
- The Royal Devon and Exeter NHS Foundation Trust website is at www.rdehospital.nhs.uk
- The Homerton University Hospital NHS Foundation Trust website is at www.homerton.nhs.uk
- The Basildon and Thurrock NHS Foundation Trust website is at www.basildonandthurrock.nhs.uk
- For more information about participation in the Puget Sound governance arrangements look at www@ghc.org
- Rubbens C, Monaghan P, Bonfiglioli E and Zadek S (2002), Impacts of Reporting: the role of social and sustainability reporting for organisational transformation, CSR Europe and Accountability, London.

4.5 Electing governors

The way elections take place will be decided by each NHS foundation trust. But, in setting up their arrangements, the real challenge is to identify an electoral process that is relevant to the local community and ensures that the true mix of socio-economic and geographical interests is represented. In a similar way staff governors are not nominations of unions or other staff groups but should be appointed on the basis of free elections of those staff who become members.

Elections to the board of governors can occur in a number of ways, for example by postal or electronic ballot, giving organisations greater flexibility to set up appropriate election arrangements. However, where an election is contested, it must be by secret ballot.

Section 10 sets out the potential electoral systems that might be used to elect the public, patient and staff governors to the Board of Governors.

4.6 Appointing non elected governors

Although it is the appointing organisations themselves who are responsible for the selection of the governor, it is important that the trusts works with the appointing organisation to ensure the appointed governor has some interest in the work of the trust. NHS foundation trusts have expressed disappointment in the general level of commitment from this group and have found that it is most likely for appointed governors to have the poorest attendance record at governor meetings.

Trusts should not underestimate the effort required to identify these governors and should ensure that the process is adequately resourced.

Primary care trust governors

As outlined above, the board of governors of an NHS foundation trust must include at least one governor from a primary care trust that the NHS foundation trust provides goods and services to. There may be more, if the trust so chooses. An NHS foundation trust should agree with the primary care trusts to which it supplies goods and services how many primary care trust governors there should be on the board of governors and the method of selection (for example rotation, one to represent all primary care trusts). They must leave the selection process to the primary care trusts themselves.

One or two governors could represent a large number of primary care trusts. Where this occurs those primary care trust governors should not be seen as representing the interests of their specific primary care trust. Their role is to provide the perspective of the wider health community and be a knowledgeable source for governors to develop better understanding of the environment in which the NHS foundation trust operates.

Moorfields Eye Hospital NHS Foundation Trust has seven 7 PCT governor positions reflecting the wide area to which the Trust delivers services. The Trust has asked for nominations that cover a range of professions and are not just commissioning or finance, on the basis that their role should be to educate and develop the governors and to inform the Service Development Strategy as the trust implements and develops it. The Trust has identified a need to have a clearly defined role for PCT governors not least when the Trust is not the main local service provider.

Papworth Hospital NHS Foundation Trust works with a number of PCTs and they were asked to select one PCT who would then be responsible for nominating a representative to the board of governors.

Bradford Teaching Hospitals NHS Foundation Trust draws most of its income from four PCTs, each of which has its own characteristics and needs. The trust felt that they all had a contribution to make at the board of governors and decided to have one governor from each of the PCTs.

Local authority governors

The board of governors of an NHS foundation trust must also include at least one governor from a local authority that falls wholly or partly within a public constituency of the NHS foundation trust. There may be more, if the Trust so chooses. Again, an NHS foundation trust should agree with the relevant local authorities how many local authority governors there should be on the board of governors and the method of selection (for example rotation, one to represent all local authorities). They must leave the selection process to the local authorities themselves. The local authority governor does not need to be elected to the board of governors nor do they need to be an elected member of the local authority - for instance they could be a relevant officer such as the Director of Social Services. Local authority governors should not be appointed to represent the interests of their specific local authority. Their role is to provide the perspective of the wider community and be a knowledgeable source for governors to develop better understanding of the environment in which the NHS foundation trust operates.

University governors

If the NHS foundation trust's hospitals include a university medical or dental school they need to have a governor appointed by that university. The NHS foundation trust should agree with the relevant universities how many university governors there should be on the board of governors and the method of selection, but must leave the selection process to the universities themselves.

Partnership governors

An NHS foundation trust must decide whether it wishes any partnership organisations to be represented on the board of governors. Where it considers it appropriate to include partnership organisations it must list the organisation(s) that can be represented on the board of governors in their constitution. The list of partnership organisations considered could include other stakeholder NHS organisations, local community groups, the business sector, the League of Friends, relevant charities, faith groups and so on. Some trusts have felt that it has been appropriate to identify staff side as a partnership organisation. The partnership organisations themselves will need to determine the selection process and then employ that process to select a governor.

4.7 Terms of Office

A public, patient or staff governor may hold office for a period of no more than three years. They are eligible for re-election at the end of that period. NHS foundation trusts may define differential periods of appointment for public and staff governors so that they do not all come up for re-election at the same time. There is no legislative cap on the total time served as a governor across electoral terms, although NHS foundation trusts should consider the Office of the Commissioner for Public Appointment's guidance on terms of office. In addition, NHS foundation trusts may decide the minimum period of time a public governor may remain a member of the board of governors.

Each NHS foundation trust can determine for itself the terms of office for all other governors.

A person cannot be a governor if:

- he/she has been adjudged bankrupt or their estate has been sequestrated and in either case he has not been discharged;
- he/she has made a composition or arrangement with, or granted a trust deed for, their creditors and has not been discharged in respect of it;
- he/she has had within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them.

An NHS foundation trust may also decide any other reasons why a person might not be elected as a governor over and above the reasons they have already set out for excluding people from being public or staff members. Other reasons for disqualifying a person from becoming a governor might include the following:

- he/she is a person whose tenure of office as the chairman or as a member or director of a health service body has been terminated on the

grounds that his appointment is not in the interests of the health service, for non attendance at meetings, or for non-disclosure of a pecuniary interest;

- he/she is an executive or non-executive director of the trust, or a governor, non-executive director, chairman, or chief executive officer of another NHS foundation trust;
- he/she is a medical practitioner that has been disqualified under section 46 of the National Health Service Act 1977, and has not subsequently had his or her name included in such a list;
- he/she is incapable by reason of mental disorder, illness or injury of managing and administering his property and affairs.

In addition, if an elected governor ceases to be a member then they cease to be an elected governor. If they are a non-elected governor and they cease to be sponsored by their organisation then they also cease to be a non-elected governor. A person who ceased to be a governor could continue to attend the board in an advisory role although they would not have voting rights.

Monitor has the power to remove one or all of the governors from the board of governors if he or she deems this necessary to deal with a situation where the trust is failing – see section 23 of the Act.

4.8 Roles and responsibilities

4.8.1 Legal minimum

Responsibilities

- The board of governors is to appoint the chairman and other non-executive directors of the NHS foundation trust at a general meeting (schedule 1, paragraph 17(1)); (There are exceptions for the initial Chair and non-executive directors. See Chapter 5.2.);
- the board of governors may remove the chairman or non-executive directors of the NHS foundation trust. Such removal must occur at a general meeting of the board of governors and it requires the approval of three quarters of the members of the board (schedule 1, paragraph 17(1));
- appointment of the chief executive by the non-executive directors requires the approval of a majority of the members of the board of governors (schedule 1, paragraph 17(4)). (There is an exception for the initial chief executive. See Chapter 5.2.);
- it is for the board of governors to appoint or remove the auditor at a general meeting of the board (schedule 1, paragraph 23(2));

- the board of governors is to be consulted on forward planning by the board of directors and the board of directors must have regard to their views (schedule 1, paragraph 27(3));
- the annual report and accounts, and the report of the auditor must be presented to the board of governors at a general meeting (schedule 1, paragraph 28);
- the Act provides that all the powers of the NHS foundation trust are to be exercised by its directors. The board of governors cannot therefore veto decisions made by the board of directors (schedule 1, paragraph 15(2)).

Conduct

- The constitution must provide for the chair of the NHS foundation trust to preside at meetings of the board of governors. The constitution must provide for another person to preside over the board of governors in the Chair's absence (schedule 1, paragraph 12);
- the constitution must provide for meetings of the board of governors to be open to the public except where there are special reasons for excluding them. While the Act does not require it the Department of Health advises the inclusion of general categories of such 'special reasons' to be incorporated in each NHS Foundation trust's constitution (schedule 1, paragraphs 13(1) and (2));
- the board of governors must meet at least once a year to receive annual accounts, auditor's report and annual report (schedule 1, paragraph 28);
- a person elected to the board may only vote at a general meeting of the board if they have made a declaration giving the details of his eligibility and stating that they are not disqualified from being a governor, either by paragraph 8(1) of schedule 1 to the Act or by other provision in the trust's constitution;
- the constitution must include details on the practice and procedure for the board of governors (schedule 1, paragraph 14(1)(c)), and can make other provision about the board of governors as the trust sees fit (schedule 1, paragraph 14(2)).

Expenses and allowances

- the NHS foundation trust may pay travelling and other expenses to governors. The rate of travelling and other expenses is to be decided by the NHS foundation trust (schedule 1, paragraph 11) and Monitor may well issue guidance on this matter;
- it is for the board of governors at a general meeting to decide the remuneration and allowances and other terms and conditions of office of non-executive directors (schedule 1, paragraph 18(1)).

Conflict of interest

- Trusts must hold a register of members of the Board of Governors and a register of the interests of governors (schedule 1, paragraph 20(b) and (c));
- Trust constitutions must make provision for dealing with conflicts of interest of members of the board of governors (schedule 1, paragraph 21).

4.8.2 Roles

The board of governors will have three types of role, each involving different levels of responsibility:

- a. **advisory:** providing a steer on how the NHS foundation trust can carry out its business in ways consistent with the needs of the members and the wider community. NHS foundation trusts will need to consider:
 - how each governor will maintain a dialogue with the membership community that they represent. This will need to include how the public interests of the local community will be represented including the interface between governors and the constituency they represent including any consultative forums already in place (for example, local League of Friends, primary care trust, Patients Forums, the Overview and Scrutiny Committee, staff groups);
 - what the board of governors will mean in practice for its local community;
 - the control that the local community currently has and how this will change when the NHS foundation trust is created;
 - the day-to-day role of the governors;
 - how the members can contact the governors;
 - governor responsibilities to the local community.
- b. **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, and acting in a trustee role for the welfare of the organisation. NHS foundation trusts will need to develop a process to bring about resolution of any action by the board of directors that appears to be inconsistent with the terms of the authorisation or the primary purpose and the mechanism for notifying Monitor if concerns about the action cannot be resolved at a local level.
- c. **strategic:** advising on a longer term direction for the NHS foundation trust so that the board of directors can effectively determine its policies. The relationship between the board of governors and the

board of directors is critical and the respective roles need to be discussed and agreed upon by both boards, to avoid confusion and creating tension that might disrupt the working of the governance arrangements.

Trusts are encouraged to develop a role for governors outside of the statutory requirements and the experience of the wave 1 NHS foundation trusts seems to have focused in four main areas.

A number of NHS foundation trusts have delegated the responsibility for the membership strategy to a committee of the board of governors. These committees work with the trust to ensure that policies are implemented to maintain and grow a representative membership. In some cases governors take responsibility for making presentations to the community and recruiting new members.

The board of directors must be able to demonstrate that they have 'had regard' to the views of the governors in drawing up their forward plans. It was concluded by many trusts that a general meeting of the board was unlikely to allow sufficient free ranging discussion and they looked for alternative means to achieve this requirement. Some have opted for joint planning days where both boards meet to discuss the annual plan and the service development strategy. An alternative approach has been to form a committee of governors and directors who are then responsible for reviewing and discussing the plans in detail before reporting back to the board of governors.

A number of NHS foundation trusts have identified particular areas of concern where they felt that a working party of governors could add value. A common topic for these groups has been access to the hospital. The inclusion of representatives from the local authority has meant that the discussion has not only covered the availability of car parking on site but has been expanded to include access roads and low cost housing for staff.

The fourth area covered is community outreach, which continues to be the most difficult area to progress. Trusts have developed a number of ways of trying to link governors with the membership including publicising contact details for members to get in touch with governors and organising activities to which members, and governors are invited. For most governors this remains an area where they currently feel unconnected with the membership.

4.8.3 Conduct

Advice on the code of conduct of both the board of governors and the board of directors is provided at Annex C. In addition, an NHS foundation trust will need to consider:

- the process for appointing the chair of the NHS foundation trust and the non-executive directors to the board of directors of the NHS Foundation trust. Monitor may issue guidance on this;
- the frequency and format of meetings of the board of governors including the details of the quorum, the person(s) who can chair the meeting in the absence of the Chair and any special reasons why the meetings would

not be open to the public. The board of governors must meet at least once a year to receive annual accounts, auditor's report and annual report. The Department of Health recommends that the board meets at least three times a year and that there should be a majority of public governors present at any meeting;

- consider which committees and sub-committees to set up (although powers themselves may not be delegated);
- the process for handling vacancies on the board of governors;
- the reasons for excluding members and non-members from meetings;
- the documents that will be made public over and above those listed in the legal minimum and the charges to non-members requesting those documents.

4.8.4 Fees and allowances

It is for the board of governors to decide whether fees should be paid to non-executive directors and, if so, how much (paragraph 18(1) of schedule 1). The Department of Health recommends that they follow sector standards. The effect of any fees on the eligibility of board members to receive social security benefits needs to be considered along with the implications for unemployed people of their availability for work.

Governors are not eligible to receive remuneration under the Act, but they will be able to claim travelling and other expenses, at rates decided by the trust itself (paragraph 11 of schedule 1). These will cover the cost of travel, child care, carers and, for example, readers for people with visual impairment

4.9 Helping governors once elected – sources of help

The board of governors will require support, and infrastructure. Points to bear in mind are:

- how best to support governors in their role to represent the views of the population served by the NHS foundation trust. For example, a staff governor will need to represent all staff members, not a specific union position or viewpoint, even if they hold office with that union (although their knowledge and experience from their union role will be an asset to the board of governors);
- the greater the board's involvement in strategy, the greater the need for resources. This is because the board will need to be more fully informed about issues;
- the secretariat arrangements for the board of governors;

- candidates for the board of governors must commit themselves to undertake training. This training will need to cover such areas as the values, principles and structures of the NHS and the trust, its financial mechanisms and its line of responsibility;
- governors will need to grasp the functions, authority, legal responsibilities and roles of the board of governors, and understand financial reports and accounts, diversity, and health and safety at work;
- new governors may be relatively inexperienced but their skills, knowledge and experience will develop over time. The NHS foundation trust should nurture this and develop the skills and roles of individual governors (see chapter 7 on induction).
- The focus in the first year of NHS foundation trust status may be to educate the public and patient governors and this has led to frustrations amongst the staff and appointed governors who are, in most cases, healthcare professionals. They tend to have a higher churn rate amongst the later category and may have a poorer attendance record. It is important that trusts recognise the differing knowledge levels and structure their support accordingly. Given their background, these governors can play a valuable role in the education process of public and patient governors.

The Royal College of Midwives and The Chartered Society Of Physiotherapy have issued *NHS Foundation Trusts: A Guide for Midwives and Physiotherapists*. As well as providing an introduction to NHS Foundation trusts for their members, this booklet includes a useful section on how to get the most out of being a staff governor. It highlights five key ways for governors to maximise their contribution:

- keep up-to-date
- keep in touch with members
- contact/liaison with user patient groups
- keep in contact with key stakeholders
- network

5. Board of directors

5.1 Legal minimum

Structure

There must be a board of directors which exercises the powers of the NHS foundation trust. The board of directors must exercise all the powers of the corporation on its behalf (schedule 1, paragraph 15(2)). The powers of the board of directors can be delegated to a committee of directors or an executive director (schedule 1, paragraph 15 (3)).

The board of directors is to consist of:

- a. non-executive directors one of whom is the Chair (schedule 1, paragraph 16(1)(b));
- b. executive directors. One of the executive directors must be a chief executive (and accounting officer) and one of the executive directors must be a finance director (schedule 1, paragraph 16(1)(a)). The executive directors must include a registered medical practitioner or a registered dentist; and a registered nurse or midwife (schedule 1, paragraph 16(2)). There may be further executive directors on the board of directors if a trust chooses (schedule 1, paragraph 16(1)).

There is a wide divergence of opinion on the optimum size of the board and what constitutes the ideal ratio of non-executive to executive directors. The average size of the board in an NHS foundation trust is twelve but the range is between ten and 16. The Combined code states that the board should not be so large as to be unwieldy but should be of a sufficient size to ensure a balance of skills and experience that meets the needs of the organisation. The board should include a balance of executives and non-executive directors such that no individual or small group of individuals can dominate the board's decision taking.

Exclusions

A person cannot be a director if he or she:

- has been adjudged bankrupt or his estate has been sequestrated and in either case he has not been discharged; (schedule 1, paragraph 16(3) and (4) in conjunction with paragraph 8(1));
- has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it; (schedule 1, paragraph 16(3) and (4) in conjunction with paragraph 8(1));

- has within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on him (schedule 1, paragraph 16(3) and (4) in conjunction with paragraph 8(1));
- in the case of a non-executive director, is neither a member of the public constituency nor the patient constituency (schedule 1, paragraph 16(4)(a)), nor, if the NHS foundation trust includes a medical or dental school, is not a person exercising functions on behalf of the relevant university (schedule 1, paragraph 16(4)(b));
- is disqualified under the Company Directors Disqualification Act 1986 (schedule 4, paragraph 68).

The constitution may also include additional eligibility criteria including:

- confirming that they will adhere to the code of conduct for directors,
- fulfilling the training requirements.

In addition, Monitor may require the directors to do, or not do, certain things, and may remove all or some directors if he or she deems this necessary to deal with a situation where the trust is failing – see section 23 of the Act.

Responsibilities

As has already been outlined above, the board of directors is to exercise all of the powers of the NHS foundation trust on its behalf. There are also a number of specific functions delegated to the directors by the Act. These are:

- each NHS foundation trust must establish a committee of non-executive directors to act as an audit committee. The audit committee should carry out the functions commonly carried out by such committees such as monitoring, reviewing and other functions as are appropriate (schedule 1, paragraph 23 (6));
- it is for the non-executive directors (subject to the approval of the board of governors) to appoint the chief executive (schedule 1, paragraph 17(2)) (There is an exception for the initial chief executive. See Chapter 5.2.);
- it is for a committee consisting of the chairman, the chief executive and the other non-executive directors to appoint or remove the executive directors (schedule 1, paragraph 17(3));
- the trust is to establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the executive directors, but the constitution may make provision on remuneration and allowances pending the establishment of such a committee (schedule 1, paragraph 18(2));
- the directors, taking account of the views of the board of governors, are to prepare the information as to the trust's forward planning in respect of

each financial year to be given to the Independent Regulator (schedule 1, paragraph 27));

- the directors are to present to the board of governors at a general meeting the annual accounts, any report of the auditor on them, and the annual report (schedule 1, paragraph 28).

Conflicts of interest

- Trusts must hold a register of the directors and a register of the interests of directors (schedule 1, paragraph 20(d) and (e)).
- The constitution must make provision for dealing with conflicts of interest of the directors (schedule 1, paragraph 21).

5.2 Creating a board of directors

Each NHS foundation trust will have a board of directors. The board of directors must be made up of non-executive directors and executive directors. The chair of the NHS foundation trust is a non-executive director who will chair the board of governors as well as the board of directors.

Usually, the Chair, like the other non-executive directors, is appointed by the board of governors at a general meeting. However, if the applicant NHS trust's Chair wants to be appointed as the NHS foundation trust Chair, then they are to be appointed as such for the remainder of their term as NHS trust Chair or 12 months, whichever is the longer.

The non-executive directors are to be appointed by the board of governors at a general meeting. However, if any of the applicant NHS Trust non-executive directors want to be appointed as NHS foundation trust non-executive directors then they are to be appointed as such for the remainder of their term as NHS trust non-executive director or 12 months, whichever is the longer.

There is no limit on the number of non-executives an NHS foundation trust may have. Monitor may issue guidance on good practice for non-executive appointments but the NHS Appointments Commission plays no role in the appointment of the board of directors unless the board chooses to appoint them to assist in the process.

Only a member of the public or patient constituencies or, if the NHS foundation trust includes a university medical or dental school, a person exercising functions on behalf of the relevant university, is eligible for appointment as a non-executive director.

The Department of Health does not expect non-executive directors also to be governors, although the legislation does not preclude it. Trusts may include such preclusions in their constitutions.

The chief executive is appointed by the non-executives, subject to the approval of the board of governors. However, if the applicant NHS trust's chief executive wants to be appointed as the NHS foundation trust chief

executive, then they are to be appointed as such and without the need for the approval of the board of governors.

The executive directors are appointed by a committee consisting of the Chair, the other non-executive directors and the chief executive.

Each NHS foundation trust must decide the composition of the board of directors and it will differ from organisation to organisation. Subject to the minimum legal requirements each board will be locally determined.

In creating the board of directors NHS foundation trusts need to:

- consider the broad range of management skills such as financial management, strategic planning, human resource management and performance management that will be required to deliver the trust's vision for the delivery of healthcare to the community served by the trust in a way that is compliant with its objectives and the terms of its authorisation;
- ensure that all directors will bring specific and general skills and perspectives to the decision making process. However, the board is corporately responsible for the decisions it makes;
- understand that non-executive directors are expected to bring independent judgement often from experience from outside the NHS. They will be able to question and probe the executives so that the board of directors can make sound and well informed judgements and act as a corporate team;
- ensure that the trust develops in ways that are consistent with the needs of its community of stakeholders in the local health economy and the wider NHS;
- set out the terms of office for the Chair and non-executive directors. The Act provides for appointment of the initial chairman and non-executive directors to be for a minimum of 12 months but after that it is for each Trust board of governors to decide locally what the terms of office should be. While the terms of office of the chairman and non-executive directors are to be determined by the board of governors of each NHS foundation trust, the Department of Health recommends that the chairman and the non-executive directors are to be appointed for a period of office not exceeding three years, but may be re-appointed for further periods of up to three years at a time;
- develop a protocol for governors to agree the appointment of the chief executive;
- the terms of office of the chief executive and other executive directors are to be determined by a committee of non-executive directors, but the constitution may make provision on these matters pending establishment of such a committee;
- set out the process for appointing non-executive directors.

5.3 Roles and responsibilities

There must be a board of directors which exercises the powers of the NHS foundation trust. The powers of the board of directors can be delegated to a committee of directors or an executive director.

In addition, the NHS foundation trust will need to clarify the different roles on the board including:

- their role in planning, strategic decision-making and resource allocation;
- their responsibility for financial, environmental, social or democratic audits;
- the role of board members in the disciplinary or grievance procedures, appeals, complaints procedures;
- the relationship with the board of governors including mechanisms for identifying differences of perspective and how they might be resolved in the NHS foundation trust;
- how the board of directors will relate both to the board of governors and the members including how the board of directors intend to have regard to the views of the board of governors in development of forward plans, and significant changes to the existing business plan or health care provision.

The NHS foundation trust will also need to:

- show how the directors can monitor the performance of the organisation and hold other management structures to account;
- describe the directors' legal responsibilities or those suggested or imposed by government guidance;
- describe the mechanisms for the supervision and appointment of senior executives;
- set out the initial remuneration regime;
- specify the documents that will be made public over and above those listed above in the legal minimum and the charges to non members requesting those documents.

The chief executive is the accounting officer of an NHS foundation trust.

5.4 Making the Board Effective

The key purpose of the Board of Directors is to ensure prosperity by collectively directing the NHS foundation trust's affairs while meeting the appropriate interests of the members and other relevant stakeholders.

Decisions will need to be taken around:

- How the Board remains focussed on its key purpose;
- The appropriate composition of the Board;
- Clarifying what are Board and management responsibilities;
- Planning and managing board and committee meetings;
- Board reporting to facilitate effective decision making;
- Developing the effectiveness of both the Board as a whole and individual Board members.

The Board of Directors need to ensure they address a number of key tasks:

- Establishing the purpose, vision and values of the NHS foundation trusts;
- Setting the strategic direction for the trust;
- Establishing the organisational structure;
- Delegation to management;
- Exercising accountability to members, largely by working through the Board of Governors;
- Preparing the organisation to operate effectively as an NHS foundation trust;
- Meeting the interests of relevant stakeholders;
- Identifying the roles of the Chair, chief executive and other executive and non-executive directors.

5.5 Learning from others

Lessons from other organisations includes:

- clear terms of reference for the board of directors are the basis for successful operation. They should assist board members to understand their individual and collective roles and responsibilities, so they operate effectively. Unless the respective roles are discussed and agreed upon by both boards, confusion will create tension and disrupt the working of the governance arrangements. This is one of the key issues to get right since it has proved in practice to be difficult to negotiate, particularly in times of crisis or in decision-making;

Best practice in all of the key areas above can be found in free fact sheets provided by the Institute of Directors at www.iod.com. There are 187 factsheets covering topics which include :

- What are the key differences between directors and managers?
- What are the duties, responsibilities and liabilities of directors?
- What should be included in a director's service agreement?
- What should a letter of appointment for a non-executive director contain?
- What is the procedure for appointing directors?
- What is the procedure for removing directors?
- What is the role of the chairman?
- What is the role of the company secretary?
- What is the role of the managing director/chief executive?
- What is the role of the non-executive director?
- What is the job description of a finance director?

- the board of directors will require a range of skills. For example, good practice suggests a board would benefit from the skills and experience of an accountant, a lawyer, an entrepreneur and expertise in human resources, customer services and marketing. They will need to bring practical knowledge of the operation of the organisation and the reality of the front-line service delivery. This knowledge is as important as technical skills. It is possible to have a board that is composed of brilliant individuals with all the relevant skills and experience and yet is completely ineffective. The selection process must ensure that the board members have complementary skills and personalities and that they are collectively organised and led.

Although it is essential for directors to operate as a team it is equally important that they maintain their independence and avoid deferring to the collective view without expressing their individual opinions as this can lead to poor decision making. Personal attributes of directors are equally as important as skills and experience. These can be classified into six groups and are relevant to the role of all directors irrespective of their position on the board. The groups are:

- strategic perception;
- decision-making;
- analysis and the use of information;
- communication;
- interaction with others;
- achievement of results.

Good leadership of the NHS foundation trust largely depends on the personal attributes of board members. As with skills and experience it is not necessary for any one individual to possess all the personal attributes listed but collectively there should be a good balance of individuals with complementary strengths and weaknesses.

The **NHS Appointments Commission** has identified three crucial public sector values that can be adapted for NHS foundation trusts. These are:

- accountability - everything done by those who work in the trust must be able to stand the test of parliamentary and regulator scrutiny, public judgements on propriety and professional codes of conduct;
- probity - there should be an absolute standard of honesty in dealing with the assets of the trust: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of NHS duties;
- openness - there should be sufficient transparency about the trust's activities to promote confidence between the Trust and its staff, patients and the public.

The Audit Commission has identified three particular tensions in the role of non-executives:

- they are part of a corporate team and should be supportive of the chairman and chief executive, but they also act as a counterbalance to the power of chairmen and chief executives;
- a good team spirit is essential to the efficient operation of the board but non-executive directors have a particular role in monitoring the performance of executive directors, which has the potential for conflict;
- it is generally accepted that non-executive directors should contribute to the development of the strategy and should not usually become involved in the detailed running of the organisation, which is the province of executive directors. But in monitoring the implementation of the strategy, non-executive directors need to be drawn into some discussion of operational issues. Further, if there are serious operational problems, the independent judgement of non-executive directors may be needed to help the board find a solution. The dividing line between strategic and operational issues is by no means clear cut.

The Financial Services Authority's **Combined Code on Corporate Governance** (July 2003) sets out recommended approaches to corporate governance. It has brought together recommendations which originated in the work of Derek Higgs and Sir Robert Smith and their colleagues. Although concerned with the private sector, it presents some useful guidance for the new NHS Foundation trust boards. It can be downloaded from www.frc.uk/combined.cfm

Remuneration

- arguments against paying fees for non-executive directors are that money creates the wrong incentives for involvement and changes the nature of engagement. However, there is a problem that only those who have a reasonable level of income or who are supported by their organisations would be able to take part if no payment were made;
- there is a case for paying fees at a level that can support, for example, travel expenses or childcare and therefore ensure the engagement of people from low income groups;

Payments to board members of public sector or voluntary organisations vary widely. For example, the median fee for lay directors of large co-ops in the UK (with turnover of more than £200 million a year) was £2,300 a year in 2001/2 with the median Chair fee £3,800. Schools and housing associations currently make no payment. Chairs of Strategic Health Authorities, NHS trusts and PCTs receive up to £21,882 depending on the size of the organisation. Non-executive directors are paid £5,673 a year.

- there has been a gradual recognition that role of the non-executive director in an NHS foundation trust requires a level of experience and gravitas that is closer to the model of non-executive directors found within public limited companies. Many have discovered that during the application process the time commitment has increased significantly and argue that they are consistently required to commit additional time to the role.

5.6 The Board Secretary

Traditionally, NHS organisations have not felt the need to include a "company secretary" type role within the executive team of the trust. However, an NHS foundation trust is a completely new kind of organisation with a very different set of legal and statutory responsibilities to which a Board Secretary could bring value. The company secretary should be responsible for ensuring that board procedures are followed and that applicable rules and regulations are complied with.

If appointed, the role of the secretary may include;

- ensuring that the NHS foundation trust complies with relevant legislation and the Terms of Authorisation issued by Monitor;
- establishing and reviewing procedures for the sound governance of the Trust;
- advising both the board of directors and the board of governors on developments in governance issues;
- ensuring that meetings of both boards and any committees run efficiently and effectively and that they are properly recorded and that directors and governors receive appropriate support and guidance.

While not a director, the board secretary should have a status and responsibilities that are equivalent to board directors to reinforce their position within the NHS foundation trust. Many NHS foundation trusts rival FTSE 250 companies in size and complexity and there is an increasing recognition within trusts of the need to recruit appropriately skilled people to the position. A good secretary can be the chairman's strongest ally in ensuring an efficient and effective board.

These issues have been explored further by the **Institute of Chartered Secretaries and Administrators** who have developed a model job description on a Board Secretary for an NHS Foundation trust. It is available at www.icsa.org.uk/pdfs/guidance/040107_JD_TrustSec.pdf

The role of the secretary is fundamentally the same irrespective of the legal format of the organisation however, the mutual sector argue that the existence of democratic structures within an organisation create a need for political skills in managing the various stakeholder relationships. The secretarial role in a mutual is key, providing support and intelligence for the Chair and chief executive. As with directors the personal attributes of the individual are equally as important as the skillset. They should be excellent communicators, diplomatic, politically astute and skilled in the art of mediation.

Want to know more?

Sources of information for the examples given above and others useful research evidence can be found at:

- further information on the NHS Appointments Commission can be found at http://www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/ModernisingProfessionalRegulation/NHSAppointmentsCommission/fs/en?CONTENT_ID=4052361&chk=wiAWEy
- further information on the NHS Confederation can be found at www.nhsconfed.org
- The Combined Code on Corporate Governance can be downloaded from www.frc.uk/combined.cfm
- further information on the Audit Commission be found at www.audit-commission.gov.uk
- further information on the Institute of Directors can be found at www.iod.com
- further information on the Institute of Chartered Institute of Secretaries and Administrators can be found at www.icsa.org.uk
- further information on the Mutual Sector can be found at www.mutuo.co.uk

6. Chair

6.1 Legal minimum

The Chair is the chair of the public benefit corporation. S/he is a non-executive and must meet requirements for non-executive directors. The Chair is not a governor.

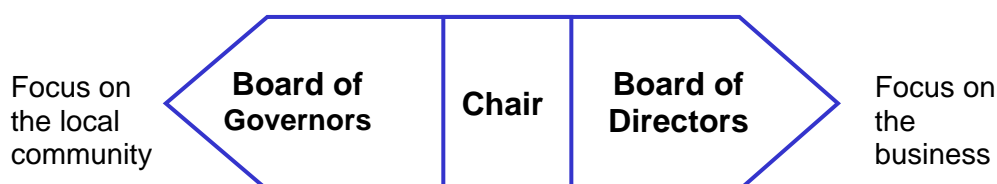
The Chair will:

- appoint the chief executive (with non-executives);
- with the chief executive and other non-executive directors appoint the executive directors; and
- chair board of directors and preside at board of governors meetings.

6.2 Role of the chair

The Chair will be pivotal to the successful performance of the NHS foundation trust. S/he will provide leadership and guidance to the chief executive and the board and be a key link between the directors and the governors. The role of the Chair of an NHS foundation trust will be different to that of a traditional NHS trust chair. Board of directors meetings in essence will be about the strategic business of the NHS foundation trust with board of governors meetings focussing more on members' needs and ensuring local communities and stakeholders have an input into the decision making processes of the NHS foundation trust.

The Chair is critical in terms of the corporacy of the NHS foundation trust. The boards must be seen as being complementary and not hierarchical or competitive with the Chair providing a critical link between them at the highest level in the organisation.



There will be times when the Chair is unavailable to attend either board and in these circumstances a non executive director should deputise in their absence. This is important as it is critical to maintain the link between the boards. The constitution should detail the procedure for dealing with the Chair's absence or conflicts of interest. The normal procedure for dealing with conflicts of interest is as follows:

- where the Chair's own appointment or removal is being discussed - the Chair could stand down from the meeting, and a non executive director could preside in their absence. This could either be dealt with in the constitution, or on a case by case basis;
- where the governors are discussing the appointment or removal of another non-executive director the chair may express an opinion on the matter, but may abstain from contributing to the decision;
- if a conflict does arise in a particular non-executive director's appointment or removal, however, the Chair could again stand aside from the meeting, either because the constitution mandates it, or because it is considered an appropriate course of action in the circumstances of the case. Some NHS foundation trusts have chosen to elect one of the public/patient governors as a deputy chair of the board of governors who then chair the board in the event of a conflict.

Amongst other things an NHS foundation trust will need to consider:

- the complementary leadership roles of the Chair and chief executive;
- the Chair's role in ensuring effective boardroom management;
- the links that need to be created between the board of directors and board of governors and the Chair's role in that;
- how the Chair will receive advice and support from both within and without the NHS Foundation trust.

The role of the Chair will be very important in helping both boards work together. In an NHS trusts the Chair and non-executives have a critical role in holding the executive team to account. While that role continues with NHS foundation trusts it also develops into something more recognisable in industry.

Want to know more?

Sources of information can be found at:

- further information on the NHS Appointments Commission can be found at http://www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/ModernisingProfessionalRegulation/NHSAappointmentsCommission/fs/en?CONTENT_ID=4052361&chk=wiAWEy
- further information schools governing bodies can be found at www.governornet.co.uk
- further information from the Institute of Directors can be found at www.iod.com
- further information from the Charity Commission can be found at www.trusteenetworks.org.uk

7. Induction

7.1 Getting skilled

An NHS foundation trust is required to operate in an efficient and effective manner. This will require some thought about the resources needed to ensure directors and governors are skilled to carry out their functions. Amongst other things, NHS foundation trusts will need to consider:

- how they will train and develop non-executives who will transfer into the NHS foundation trust from the successor NHS trust, recognising that the skills needed and requirements of their positions will be changing;
- specific training needs of prospective candidates for governors and provision of a range of accessible opportunities for involvement in decision-making. This is particularly important for people with no prior experience of committees and could contribute towards ensuring that there is appropriate and representative pool of candidates for election to the board of governors in later years;
- how they will train and develop new directors and governors. Board members need to be familiarised with the organisation and provided with all relevant information: the aims of the trust, who it benefits, the boundaries within which it works and their role as trustees;
- matching the induction programme to the needs of the trust: Each programme should be adapted so that information is targeted and communicated appropriately;
- establishing a more generic training and development programme for the NHS foundation trust. As the NHS foundation trust becomes more mature it may be able to identify potential non-executive directors from its board of governors and could use the board of governors to build up the skills of those people.

Induction does not begin when board members are elected or appointed. Potential new governors or non-executive directors should be able to find out more about the organisation and their role on the board before actually joining. Many trusts provide sessions on an overview of the organisation, the role of the governor and the election process during the run up to an election. and also provide open days where non-executive candidates can find out about the trust. New board members will need to understand:

- the structure of the organisation;
- the roles, responsibilities and accountability of the boards of governors and directors;
- the use of committees and working groups as well as their terms of reference;

- the relationship between the board and staff, including guidance on how and when it is appropriate to contact a member of staff directly;
- the media policy and what to do in the event of a member of the press contacting them directly;
- an overview of current NHS initiatives and how they impact on the trust.

Induction pack

New members should be given an induction pack, including the above information. The contents need to be reviewed regularly. It is helpful to include a list of names and contact details of board members and brief career summaries if they are available. Make sure the contents of the pack are reviewed and updated regularly.

Getting to know the organisation

Trusts may consider holding sessions for new board members followed by a social event, so they have an opportunity to get to know each other. The session(s) may include:

- a briefing on the organisation's history;
- a review of important documents such as the constitution and other organisational policies;
- an overview of the financial position of the trust and an introduction to NHS finances;
- a review of the current annual plan and the key long term objectives contained within the integrated business plan;
- a site visit to see the work of the hospital and to be introduced to people involved;
- a meeting with the Chair;
- a meeting with the chief executive.

The meetings will be an opportunity to build up a picture of the organisation's work and the key challenges and opportunities it will be facing in the coming months. The meeting with the Chair and the chief executive can also identify the skills and experience the new governor brings and any support needs they may have. It should be remembered that the time commitment required by governors is significantly less than that required by employees and non-executive directors therefore it is important to structure any induction appropriately. Governors need to know enough to be able to carry out their role, but not enough to be overloaded or to get a misleading impression of the level of work involved.

Given the diversity of governors and their different background and expertise it is important to carry out a skills audit so that individual support needs can be identified. Having a skills analysis of governors and their interests can also be helpful in identifying appropriate roles on committees and work groups.. Some organisations allocate a training officer to work with both paid and unpaid individuals to design a programme suited to their needs. This could include running training sessions or, for example, allowing a governor to attend one training course per year (depending on the budget). As governor roles develop they are increasingly identifying those areas where they feel they require further information and training.

Want to know more?

Additional sources of information be found at:

- NCVO Trustee Information Briefings: *Skills boards Require; Training for Trustees and Committees; Finding New Trustees; A Job Description for a Trustee* (SAE to Trustee and Governance Team).
- *The Trustee and Governance Briefing Pack*, available online or from the NCVO Trustee and Governance Team, May 2001.
- Trustee board Development Programme Factfile *Designing a board induction programme* (Full Factfile £4.50 from Trustee and Governance Team).
- *The Twenty-Minute Guide to Becoming a Trustee* Help the Hospices (2000) The Ford Partnership and Help the Hospices.
- *Guide to board Development: Mentoring* (NCVO, available in 2001).
- Charity Commission *Welcome* leaflet for new trustees (available from the Charity Commission)
- further information on training and induction provided by the Institute of Directors can be found at www.iod.com
- further information on training and induction provided by the Institute of Chartered Institute of Secretaries and Administrators can be found at www.icsa.org.uk
- NHS Appointments Commission
http://www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/ModernisingProfessionalRegulation/NHSAappointmentsCommission/fs/en?CONTENT_ID=4052361&chk=wiAWEy

8. Liabilities

8.1 Liabilities in the event of the failure of an NHS Foundation trust

Should an NHS foundation trust fail then it would be liable for its liabilities and debts the same way as a legal person. The members of an NHS foundation trust cannot be liable for its debts or liabilities in any way if it fails, as the legislation does not allow the trust to transfer liability to them.

Sections 24 - 26 of the Health and Social Care (Community Health and Standards) Act 2003 contain powers to create, by secondary legislation, a failure regime for NHS foundation trusts. The regime will be established through application and modification of Parts I and IV of the Insolvency Act 1986 which relate to voluntary arrangements and winding up respectively. The failure regime will be based on these well-established insolvency procedures for companies but with modifications applied to allow for the protection of essential NHS services and assets.

8.2 Indemnity Assurance

The position with indemnity insurance is similar to that for NHS trusts. The NHS foundation trust is liable for its liabilities and debts in the same way as a legal person, and will need to ensure that it has adequate cover for these liabilities. They will have access to schemes administered by the NHS Litigation Authority in the same way that NHS trusts do. As far as liability of employees is concerned, according to common law, an employer is vicariously liable for the actions of employees when acting in their capacity as such.

Staff contracts and the contracts of executive members of the board of organisations (whether companies, NHS trusts or other) often include provisions on liability for the actions of individuals. We would expect that the NHS foundation trust would be vicariously liable for actions that are carried out by governors and non-executive directors in their capacity provided that they are acting in good faith.

The provisions in the Insolvency Act which cover the consequences of deliberate fraudulent actions will be applied to NHS foundation trusts. This would mean that where directors have deliberately and fraudulently continued to trade with creditors, they may be made personally liable for the relevant debts of the organisation.

9 Registers

9.1 Legal minimum

An NHS foundation trust must have:

- a register of members showing, in respect of each member, the constituency and, if relevant which class within that constituency, to which he/she belongs (schedule 1, paragraph 20(1)(a));
- a register of members of the board of governors and a register of their interests (schedule 1, paragraph 20(1)(b) and (c));
- a register of directors and a register of their interests (schedule 1, paragraph 20(1)(d) and (e)).

The constitution may make further provision about the registers including, in particular, admission to, and removal from, the member register (schedule 1, paragraph 20(2)). Except in circumstances prescribed in regulations under the Act, registers must be available for inspection by the public (schedule 1, paragraph 22(3)).

The Public Benefit Corporation (Register of Members) Regulations 2004 came into force on 1 April 2004 and set out the circumstances in which the register of members should not be made available to the public. These are:

- the register of members of the patients' constituency (if the NHS foundation trust has one); and
- where a member has requested not to be included on the register.

9.2 Making it real

In creating its registers, each NHS foundation trust will need to:

- consider what, if any, additional information they will record on members and whether this forms part of the publicly available official register. The registers must as a minimum contain the names of members and governors. The director register must as a minimum contain the names of directors and their interests. No other details are required on the register. It is anticipated that official register will not include a home address, but the NHS foundation trust will still need to keep a record of contact addresses. This need not form part of the register that is publicly available, and probably should not to avoid the register being exploited by others. Company directors often give the company as a contact address to avoid exposure to unwanted contacts;

- The registers will need to be maintained and the trust will have to devise a mechanism for ensuring that those no longer qualifying or wishing to be members are removed. This is relatively easy to achieve with staff members where the process for leavers could include informing the membership office of their leaving date. The mechanism for removing and adding people to register need not be the same for each register and the conditions that apply need not be the same for each register.

The Department of Health expects to see the plans to create the register of members as part of the application process and for the registers to be operated as cost effectively as possible. All trusts agree that effective management of the register requires a clear vision of the data to be stored, an overview of reports that may be required and an investment in sufficient resources. There are a number of models amongst NHS foundation trusts on how registers are maintained but the most important distinction is between whether this is operated in-house or externally.

Any election candidate who obtains a list of the members of the NHS foundation trust and sends literature to them during the election period is very likely to be in breach of the expenses rules (especially if the trust has followed the model rules set out in Section 10). However, as there is no legal requirement on the applicant Trust to make its register of members publicly available until it is authorised as an NHS foundation trust then trusts should not make them available for the initial elections.

Once an NHS foundation trust is authorised by the regulator, it must ensure that its register of members are maintained in manner which complies with paragraphs 20-23 of Schedule 1 to the 2003 Act, and with these regulations.

As well as ensuring that information about patient members is not included in the publicly available register, the regulations also allow any member to request that their details are not made available to the general public through the register. To ensure compliance with both European Community law and the Data Protection Act 1998, NHS foundation trusts must ensure that members are aware of this right to object to their personal data being disclosed. Most trusts have found that including this on the application form is the most effective means of achieving this.

The Regulations only restrict access by the public to the members' register. The Regulations will not prevent an individual from having access to the full register of members if this is necessary for them to carry out legitimate statutory functions. This may include, for example, the Returning Officer for elections to the board of governors.

The costs of maintaining membership should be seen in the context of the Government's requirement that patients and the public are kept informed about what is going on locally in the NHS. Some NHS foundation trusts have sought to reduce these costs by manning the membership office with volunteers. With a member-led organisation, the membership infrastructure

should become the main centre of focus for that activity. In other words, much of the membership activity should build on existing processes to engage with patients and public and wherever possible NHS foundation trusts should look to adapt current processes. Further advice on creating memberships can be found in Chapter 3.

10. Electoral Systems for NHS Foundation trusts

This section sets out the potential electoral systems that might be used by NHS foundation trusts to elect the public, patient and staff governors to the Board of Governors. It provides a range of options that are regarded as acceptable good practice in modern democratic structures. This guidance is supplemented by a set of model election rules for NHS foundation trusts to use as a guide in drawing up their constitution and implementing their preferred electoral system. The model rules set out a simple postal voting system for elections to NHS foundation trust Board of Governors. Whilst NHS foundation trusts are not obliged to follow these rules, they are intended to ensure best practice. If trusts wish, for example, to use internet or phone voting alongside postal voting, they will need to set out the rules which they propose to apply for such procedures. If they wish to insert rules on supporters for nominations they may do so.

Trusts should be aware that there is a risk that an election could be exposed to legal challenge if the processes and procedures for holding election are unclear or inadequate or if the trust does not follow them in practice. Monitor will not authorise a trust if there is any doubt about the legality of the election process.

The Health and Social Care (Community Health and Standards) Act 2003 requires each NHS Foundation trust to secure that its constitution is in accordance with Schedule 1 to the Act and in accordance with any regulations as to the conduct of elections to the board of governors. Regulations may in particular provide for:

- Nomination of candidates and obligations to declare their interests;
- Systems and methods of voting, and the allocation of places on the board of governors, at contested elections;
- Filling of vacancies;
- Supervision of elections;
- Election expenses and publicity;
- Questioning of elections and consequences of irregularities.

The only requirements specified in the legislation are that NHS foundation trusts must include provision in their constitutions on the conduct of elections and, as required in section 35(5) of the 2003 Act, that any contested elections must be by secret ballot. If there is no secret ballot the trust will not be authorised.

Applicants should note the Act requires that NHS foundation trust constitutions comply with the regulations when they come into force. Applicants therefore need to plan now for an electoral process that will comply with the regulations when they are made and will therefore need to include provisions in their constitutions that are adequate from the outset.

This guidance and the model election rules are intended to be helpful tools to aid applicants with this process.

PART ONE: MEMBERSHIP CONSTITUENCIES AND ELECTIONS

10.1 Constituencies

An NHS foundation trust's membership is made up of a number of constituencies, including as a minimum:

- One or more public constituencies consisting of people living in a geographical area or areas (defined in terms of local government electoral areas);
- A staff constituency consisting of all the staff members which may be subdivided into a number of classes.

An NHS foundation trust may also choose to have a patient constituency consisting of patients and carers of the trust. This constituency may also be subdivided into a number of classes.

The constitution must set out the minimum number of members for each of its constituencies and, if there are any, in classes within those constituencies.

Each member must have the right to vote for the governor or governors that are to be elected from their constituency, or class within a constituency. Within each constituency or class, each member may elect any of their number to be a member of the board. In other words, only members of that constituency/class may stand and only members of that constituency/class may vote. So the constitution must provide for at least one position on the board of governors to be elected by each constituency or each class.

No individual can be a member of more than one constituency (or class). So anyone eligible for more than one constituency or class (e.g. a local resident who had also been a patient or carer) would have to choose which constituency/class to join. People eligible to be members of the staff constituency are not eligible to register as members of the public or patient constituency. Trusts will need to ensure systems are in place to prevent dual registration particularly if they adopt opt-out systems (where individuals are automatically made members, unless they object) for patient or staff membership.

10.2 Sub-division of constituencies

The Act allows for subdivision of each membership category in a number of limited ways and NHS foundation trusts cannot sub-divide beyond this. It is not possible to define governor posts by different constituencies but hold a single election in which all the members vote for all governor posts.

Establishing several Public Constituencies

An NHS foundation trust may sub-divide its public membership into two or more constituencies, but it can only do so on a geographical basis, by having public constituencies that are divided along local authority electoral boundary lines.

Division of the Staff Constituency

The staff constituency may be divided into two or more classes that together include all the staff members. This may be done in various ways provided the basis for subdivision is set out clearly in its constitution. An NHS foundation trust might, for example, decide to divide the staff constituency by professional group e.g.:

- (a) medical and dental practitioners
- (b) other clinical staff not in (a)
- (c) all other staff not in (a) or (b)

This could be expanded to bring out other key groups such as AHPs, ancillary staff, admin and clerical, managers etc. An alternative approach would be to define separate classes to cover different hospital sites or to divide staff into speciality groups.

Division of the Patient Constituency

Like the staff constituency, the patient constituency may be divided into a number of classes that together include all the patient and carer members. Again, this may be done in various ways provided the basis for subdivision is set out clearly in its constitution. If an NHS foundation trust with a patient constituency does decide to sub-divide it into classes, there must be a minimum of three, one of which must be for the carers of patients.

An NHS foundation trust might for example, divide the patient constituency into separate classes based on particular groups of conditions or by attendance at a particular hospital. Trusts that adopt this approach will need to consider whether some patient members might not wish to be classified by condition but would prefer to belong to a general class.

10.3 Factors to consider in deciding constituencies and classes

When determining the constituencies, and whether to sub-divide them into any classes, the NHS foundation trust needs to consider how it can best make the board of governors representative of the membership. A number of factors will need to be considered and these will have different weightings and importance in each trust. They may include some of the following:

- **The number of governors to be elected:** NHS foundation trusts can decide whether to opt for a large number of small constituencies/classes each electing one governor or a smaller number of larger constituencies/classes each electing a number of governors;

- **The distribution of the membership:** Some NHS foundation trusts will serve largely urban communities, others are more rurally based and many serve a combination of both. An NHS foundation trust will need to ensure that it adopts constituencies which give fair representation to the diversity of the various geographical communities it serves;
- **The gender balance of the membership:** If an NHS foundation trust based its membership solely on a residential requirement, it could expect its membership to be split equally between the sexes. An NHS foundation trust that provided services that were not equally divided between genders might therefore wish to reflect this by providing for particular patient classes;
- **The age profile of the membership:** An NHS foundation trust should also consider whether its membership should be relatively equal across age bands, or whether certain groups should have particular representation. The area served may have a disproportionate number of certain age groups, members might tend to come from certain age groups, or the nature of the trust's services might be more geared towards age groups e.g. children, pregnant women, older people. Whilst doing so, the trust should determine within its constitution the lower age of membership and the age at which members may become governors. These ages may be different.

10.4 Registers

Every NHS foundation trust must maintain a register of members showing, in respect of each member, the constituency (and class if appropriate) to which she or he belongs:

- *Public constituency* - residence in the public constituency area;
- *Patient constituency* - attendance for treatment as a patient or carer of a patient as defined in the trust's constitution;
- *Staff constituency* - a staff member as defined in the trust's constitution.

The register needs to be subdivided into public, patients (if included) and staff constituencies and then further subdivided by class if the trust decides on subdivision of the patient and staff constituencies for electoral purposes. For example, if there are four separate public constituencies then each of those constituencies will need a separate section on the register of members.

Trusts must make the register of members available for public inspection except in prescribed circumstances. The Public Benefit Corporation (Register of Members) Regulations 2004 make provision for certain matters in the register to be excluded from public inspection.

PART TWO: THE ELECTION PROCESS

10.5 Timetable

The timetable for elections should be paced to allow for reasonable time for the completion for each stage and as a minimum should include the following:

Stage in Process
Appointment of Returning Officer
Publication of Notice of Election (which also seeks nominations)
Delivery of nomination papers
Publication of statement of nominated candidates (after Returning Officer has checked they are eligible under the constitution)
Date beyond which a person who becomes a member of the trust cannot vote at the election
Withdrawals by candidates
Request by Trust for candidates to submit information about themselves
Option of meetings for members to ask questions of candidates
Notice of the poll
Distribute ballot papers including information about candidates
Deadline for completed ballots to be received
Counting of ballots
Communicate outcome to successful and unsuccessful candidates
Communicate outcome to Members
Governors take up seats

Trusts will need to ensure that they allow sufficient time for each stage of the process and that, as a minimum, their constitutions cover the processes that are specified in the Act for inclusion in regulations. The model election rules set out a proposed minimum timetable for the key stages in the election timetable. Applicants must ensure that there is sufficient time allocated for each step in the process to be completed.

10.6 Returning officer

Each NHS foundation trust must appoint a Returning Officer to run the election. The returning officer should not be a member, director or employee of the applicant NHS Trust or employed by, or on behalf of, a person nominated for election.

10.7 Nomination of candidates

NHS Foundation trusts need to clearly set out how members might nominate themselves to be elected as governors. Members should be made aware of the process. The newsletter is a good way of communicating the forthcoming election to members and seeking nominations. Most trusts hold meetings for potential candidates explaining the election process and offering support to complete the application forms.

The constitution must clearly set out the procedure for nominations. Election Regulations are likely to require that a candidate declares his or her interests as part of the nomination. It is likely that, as a minimum, candidates will be required to declare if they are a member of a political party, or if they have a significant financial interest in the NHS foundation trust.

Anyone who is registered as a member of a particular constituency or class will be eligible to be nominated to stand for election in that constituency or class. The legislation sets out a limited number of exclusions and trust constitutions may include other limited exclusions consistent with the legislation and may include age restrictions where appropriate.

The legislation prevents the use of selective criteria and trusts will not be able to adopt nomination procedures that would prevent any eligible member from standing for election. The External Reference Group on Governance has advised against building in anything to the nomination process that might restrict those traditionally excluded from becoming involved.

While NHS foundation trusts will wish to be as inclusive as possible, the nomination process must be seen to be fair.

The Commission for Racial Equality (CRE) does not want to see positive discrimination for people from black and ethnic minorities, but trusts can support individuals from those communities. The Co-operative Group carries a diversity statement at the top of every ballot paper and the CRE recommends that trusts put a welcoming message in all their literature such as: *"...this trust is particularly committed to all aspects of the community, and would particularly welcome and support applicants who are female, disabled or from a black or ethnic minority"*.

In its call for elected representatives in 2003, the Newcastle New Deal for Communities partnership asked for nominees in seven different languages, for the candidates to indicate the constituency they wished to stand for, include nominees and an election statement of up to 150 words. The use of a photograph was optional.

NHS foundation trusts may make provision in their constitution for a governors support committee. In that event, the constitution must make the purpose and membership of such a committee clear. The election regulations are unlikely to include requirements in relation to such committees but the rules the trusts adopt should ensure that the existence of the committee, if there is one, is advertised to members. There are a number of approaches a trust could take. For example, a trust could establish the committee within the membership office of the trust itself. Staff in the office could assist potential candidates in finding the supporters they require for nomination if provision is made for this. This could be particularly important for Trusts that have a large patient membership with a wide geographical spread, as some members may not know who else belongs to their constituency or class. The 2004

Regulations prescribe that information in respect of patient members is to be excluded from inspection by members of the public.

10.8 Declaration of nominated candidates

The constitution must make provision for the Returning Officer to publish a statement of nominated candidates. The regulations are likely to include requirements on the publication and content of the statement and on provision for candidates to withdraw and the model rules set out detail on this.

10.9 Providing support to candidates

NHS foundation trusts will need to consider the level of support they may need to provide to candidates to ensure that they understand the processes involved. For example:

- advice on what the commitment to standing for election as a governor would involve;
- whether candidates should provide an election statement and if so, how will this be done;
- how a statement will it be recorded and circulated to the membership and what assistance will the NHS foundation trust provide.

Many trusts achieve this by running a series of meetings and inviting those members who have expressed an interest in standing for election.

10.10 Method of election

The constitution should set out how the method of election – contested or uncontested - should be decided. The election regulations are likely to set out how this decision should be made. If a contested election is required paragraphs 2.8 and 2.9 (below) set out the options likely to be available for NHS foundation trusts. Paragraph 2.7 sets out what should happen where there are more places than nominations; the model rules set out further details.

10.11 Where there are more places than nominations

Trust constitutions must provide for a majority of the board of governors to be elected by the public members – i.e. the members of the public and patient constituencies. If there are too few candidates putting themselves forward for election then the NHS foundation trust will need to be clear about its

processes to ensure that all its seats are filled. In the first instance this should include measures to encourage members to stand for election.

In its election for the Bath and Wiltshire Area in 2003, the Co-operative Group South West Region received four nominations for four places. While no election was needed, the election addresses of the candidates were circulated to members so that they would have an understanding of the perspectives of their newly elected representatives.

10.12 Electoral Systems

The constitution must clearly set out the chosen method for contested elections for each constituency and class. The election regulations are likely to define the range of election systems which NHS foundation trusts may use as¹:

Single Transferable Vote

The Single Transferable Vote system is essentially preferential voting in multi-member constituencies. Voters are able to rank as many candidates as they wish in order of preference. Any of those candidates who reach a certain quota are deemed to have been elected. The surplus votes of candidates elected on the first count and the votes of those with fewest votes after subsequent counts are distributed on the basis of preferences to the remaining candidates until sufficient candidates reach the quota and are, as a result, elected

First past the post

The first past the post system is currently used for electing members to the British House of Commons. The winning candidate simply gains more votes than any other candidate on a single count. This need not be an absolute majority of the votes cast in a constituency.

A variant of the first past the post system, which is used in some local authority elections, is to have multiple candidates elected from a single constituency. In such a system, each voter has as many votes as there are candidates to be elected.

If applicants choose this latter system, however, they should be aware that there is the possibility that only a subset of posts might be filled, and a second election would therefore be necessary. Where multiple candidates are to be elected from a single constituency, the single transferable voting system ensures that all posts are filled.

¹ As defined by the Jenkins Report

Alternative Vote

The Alternative Vote is a majoritarian system. Winning candidates secure the support of over half the voters in a constituency. The vote is exercised by recording preferences against the candidates on the ballot paper. If no candidate receives more than half of the votes cast on the first count of first preference votes, the candidate who received the fewest first preference votes is eliminated and his/her second preferences are distributed between the other candidates. This process continues until one candidate has achieved an overall majority. The model rules do not include any specific rules on the detail of the AV system, although we hope that the regulations will. Trusts wishing to use this system would need to include appropriate rules in their constitution.

10.13 Systems of voting at contested elections

Regardless of the election system chosen, the voting must take place by secret ballot. The model election rules set out two examples of voting systems.

Trusts wishing to include provisions for both electronic or phone voting, or voting by hand, will need to ensure that the systems, and rules set out in their constitution are robust and meet the statutory requirement of a secret ballot. Applicants may wish to consider the experience of the voting systems piloted in local authorities earlier this year if they are considering the use of technology.

10.14 Examples of how other organisations have run elections

One size does not fit all. The following list shows how some of the electoral systems which NHS foundation trusts may use have been employed by mutual and other organisations to achieve a representative Board of Governors (or their equivalent).

First past the post

For election to the Board of Directors to the Oxford, Swindon and Gloucester Co-op, candidates were asked to identify the district they came from and this was included on the ballot paper. All members could then vote for up to seven candidates regardless of the district in which the member resides.

Single transferable vote

The Ocean New Deal for Communities partnership allowed members to have up to as many votes as there were candidates. Each vote was cast on a preference of 1, 2, 3, etc with the successful candidates then elected on a proportionate basis.

Single transferable vote

In Northern Ireland where historically votes have been cast on a bi-partisan basis, each of the constituencies at the 1998 Assembly elections delivered a variety of members, often from both sides of the divide. In addition the process allowed for representation of minority parties for the first time such as the Northern Ireland Women's Coalition.

The alternative vote

The Report of the Independent Commission on the Voting System (the Jenkins Report) concluded that the best way to ensure representative system is through electing people on a constituency basis through an Alternative Vote system. The Commission saw its key advantage as one of increasing voter choice and of ensuring that all those elected in a constituency would have majority support.

10.15 Processes for contested elections

Each constitution will need to set out the process for the chosen electoral system. The model rules set out more detail on this. As a minimum the process will need to include:

- **The eligibility of members to vote.** This will include the point at which the register is closed for electoral purposes;
- The form of the **postal ballot paper** and how the ballot paper is to be distributed;
- The **Notice of the poll** to be published by the Returning Officer, and the content of that notice. The notice must be formally issued by the Returning Officer, and may appear on the Returning Officer's website, or the Trust own website. Trusts do not need to distribute this notice to all members - the ballot paper will provide voters with the information they require;
- The **procedure for voting**;
- The procedure for **counting the votes**. The constitution must set out the detail of the requirements on the Returning Officer with regard to counting the votes. The election rules set out the detail on this for all first past the post and single transferable voting systems, as well as detail on what grounds ballot papers are to be rejected (in whole or in part);
- The **declaration of results for contested and uncontested elections**. The Rules will require that the Returning Officer must declare the result of the election and give notice to the chairman of the corporation;

- The **sealing up of documents** relating to the poll. The rules will set out further details on this and the retention of documents.

10.16 Information to Members on Voting

Whilst the electoral process will be understood by the NHS foundation trust, members' involvement in it will only be occasional. When an election is called trusts will need to ensure that Members have up to date information about the electoral process and understand why their vote matters. The sort of information may include:

- the roles and responsibilities for the board of governors;
- how the board of governors is constituted;
- what this means for the membership community;
- the reasons behind the chosen electoral system;
- nomination procedures;
- why their vote matters;
- how and when to vote;
- how they will be informed of the outcome;
- the term of office for the governors they elect;
- where to go for more information or if they have any questions.

10.17 Election expenses and publicity

NHS foundation trusts need to maintain a prudent approach to the expenses involved in its electoral processes. The election regulations are likely to limit expenditure and publicity to activity undertaken by the NHS foundation trust itself on behalf of candidates.

NHS foundation trusts may fund a limited amount of publicity to support each candidate on a fair and equitable basis, for example by facilitating the publication and distribution of a leaflet including all of the candidates' election statements, or arranging a public meeting of candidates.

The model rules allow for some minimal expenses by each candidate. Trusts can chose their own limit of expenditure, but the provision is intended to allow candidates to cover incidental expenses- such as travelling to public meetings, arranged by the trusts, or other "personal and administrative" expenses only. It is not intended to allow for expenses connected to campaigning.

10.18 Supervision of elections

The process of the election will be supervised by the Returning Officer. Those responsible for independent scrutiny of elections will have access to the full register of members, i.e. including information on patient members that is not available for public inspection. Trusts should ensure that

appropriate confidentiality clauses are built into the arrangements for independent scrutiny.

10.19 Questioning of elections and the consequences of irregularities

The NHS foundation trust must provide a clear mechanism for concerns about the electoral process to be answered.

The electoral rules will need to give the Independent Regulator jurisdiction to investigate where an application is lodged in respect of an alleged breach of the rules once the election results have been declared. NHS foundation trusts must ensure that they make all necessary documents available for inspection for the Regulator and fully co-operate in any such investigation.

10.20 Vacancies

Finally, the constitution will need to make provision for filling vacancies that occur outside the normal cycle of elections, or as a result of a completed election process which results in vacancies remaining.

Where there is a mid term vacancy many trusts allow for the governors to invite the next highest polling candidate for that seat at the most recent election, who is willing to take office, to fill the seat until the next annual election.

10.21 How to use the model rules

The model rules set out two systems of voting - first past the post and single transferable voting, alongside some general rules covering the election process regardless of the method chosen.

In rule 13, trusts must insert the relevant provision of their constitution that disqualifies members from being governors. Some provisions have been placed in square brackets to show that they are suggestions, which can be tailored, or where the context allows, deleted, as applicants see fit without affecting the remainder of the rules.

The rules provide for both single transferable voting elections and first past the post elections. The rules that are prefixed with the letters "stv" relate only to the former system, and the rules with the letters "fpp" relate only to the latter.

Want to know more?

- The Monitor website can be found at www.nhsft-regulator.gov.uk
- Electoral Reform Services (ERS) can provide NHS foundation trusts with a range of support from running the entire electoral process to providing advice on systems and approaches to providing external scrutiny of the process and results. ERS's NHS Foundation trust Team can be contacted at Independent House, 33 Clarendon Road, London N8 0NW, 0208 365 8909, www.electoralreform.co.uk
- Computershare provide a range of services for membership based organisations and can be contacted at PO Box 1313, The Pavilions, Bridgwater Road, Bristol BS99 2GE, 0870 889 0114, www.computershare.com
- The Electoral Commission is an independent body that was set up by the UK Parliament in November 2000 with the aim to increase public confidence in the democratic process within the United Kingdom - and encourage people to take part - by modernising the electoral process, promoting public awareness of electoral matters, and regulating political parties. Further information is at www.electoralcommission.gov.uk
- The Jenkins Report can be found at www.archive.official-documents.co.uk/document/cm40/4090/4090.htm
- The Government's view on electoral systems and voting methods including electronic voting can be found on www.odpm.gov.uk

Annex A: Ten key points about NHS Foundation trusts

NHS foundation trusts will be firmly part of the NHS and subject to NHS standards, performance ratings and systems of inspection. They will treat NHS patients according to NHS quality standards and principles – free care based on need, not ability to pay.

NHS foundation trusts will be established in law as independent public benefit corporations. This will mean far greater local ownership and involvement of patients, the public and staff rather than control from the Department of Health. The principles behind NHS foundation trusts build on the sense of ownership many local people and staff feel for their hospital.

NHS foundation trusts will be democratic. Local people and staff will directly elect representatives to serve on the board of governors. The board of governors will work with the board of directors - responsible for day-to-day running of the Trust - to ensure that the NHS foundation trust acts in a way that is consistent with its terms of authorisation. In this way, the board of governors will play a role in helping to set the overall direction of the organisation.

NHS foundation trusts will prevent privatisation of the NHS. They will be required in law to use their assets - such as land and buildings - to promote their primary purpose of providing NHS services to NHS patients. A legal lock will protect these organisations from the sort of 'de-mutualisation' we have seen in the Building Society sector and prevent any threat of future privatisation.

NHS foundation trusts will operate within a clear accountability framework. They will not be left to sink or swim, allowed to 'cherry pick' services or set loose to pursue organisational goals at the expense of the needs of their local health community.

NHS foundation trusts will be there to treat NHS patients, not to make profits or to distribute them. Most of their income will come through agreements reached with local NHS Primary Care Trusts to provide locally relevant services for NHS patients at the national tariff rate. Private work will be strictly limited.

NHS foundation trusts are at the cutting edge of the Government's commitment to devolution and decentralisation in the public services. They will not be subject to direction from Whitehall. Local managers and staff working with local people - rather than remote Civil Servants - will have the freedom to innovate and develop services tailored to the particular needs of their local communities.

NHS foundation trusts are not about elitism. All NHS trusts will get help and support so they too are in a position to apply for foundation status.

NHS foundation trusts will work in partnership with other NHS organisations. They will remain part of the NHS. They will have a duty in law to co-operate with other local partners using their freedom in ways that fit with NHS principles and are consistent with the needs of other local NHS organisations. They will be overseen by the Independent Regulator, Monitor, who is accountable to Parliament, and be inspected by the Healthcare Commission.

NHS foundation trusts will be able to direct their services more closely to the communities they serve with freedom to develop new ways of working that reflect local needs and priorities. This will be done within the NHS framework of standards and inspection that safeguards the quality of NHS care. Direct elections of governors by local people and staff will get local hospitals better focused on meeting the needs of the communities they serve.

Annex B: Summary application requirements

Application requirements on governance are set out in the *Applying for NHS Foundation Trust Status: Guide for Wave 3 Applicants*, issued in November 2005 to wave 3 applicants.

Eligibility

To become an NHS foundation trust organisations must be eligible to apply. The current eligibility requirements are as follows:

Current 3 star rated acute, specialist, or Mental Health NHS trusts are eligible to apply for foundation trust status from November 2005. These organisations will be known as Wave 3 applicants. Wave 3a embarked on this process in January 2006.

DH development phase

Once NHS organisations have met the eligibility requirements above, they can then apply to enter the DH development phase of the NHS foundation trust application. In this phase applicants are required to:

- develop a 5 year strategic integrated business plan (IBP), with developmental support from the DH and external consulting advice from a professional firm;
- prove that they have strong leadership and a commitment to modernising services for the benefit of patients and service users and their local communities;
- have the support and involvement of staff and other local stakeholders for their vision for reform;
- undertake a 12 weeks consultation of their strategy in their local community;
- be subject to an independent “historical” due diligence report from an accounting firm.

Secretary of State Support

Once the statutory 12 week public consultation process has been completed, and the requirements in the DH development phase have been met, applicants need to secure the support of the Secretary of State to move forward to Monitor’s assessment phase. Whilst the Secretary of State’s support is a legislative requirement for applicants to obtain, it is not a guarantee that applicants will be successful in the Monitor assessment and authorisation phase.

For Wave 3 applicants, Secretary of State support will be dependent on:

- satisfactorily completing the DH development phase above; and

- the findings of independent accounting firm's historical due diligence report, which will take into account the findings of the SHA diagnostic programme (if the applicant has completed this programme). The SHA diagnostic programme is outlined in section 3.5 below.

As part of the development phase a historical due diligence report will be prepared on each applicant. This report will highlight the underlying financial position of the trust and will indicate the risks associated with achieving sustainable surplus in the future to meet Monitor's assessment criteria. This report will take into consideration the findings of the SHA diagnostic programme discussed below.

Monitor's assessment phase

Once an applicant has secured the support of the Secretary of State they can formally apply to Monitor to enter Monitor's assessment phase. To be authorised as an NHS foundation trust, an applicant will need to demonstrate that they are:

- Legally constituted;
- Well governed; and
- Financially viable

This means applicants must:

- Ensure their constitution complies with the Act and is otherwise appropriate;
- Ensure the provision of mandatory services in the business plan and that the applicant can and will comply with the terms of the license;
- Make governance proposals which provide a representative and complete governance strategy;
- Provide Board certification that the applicant has the organisational capacity to deliver the business plan;
- Provide a Board statement which confirms sufficient working capital for the next 12 months and is accompanied by the appropriate professional opinion on this statement;
- Provide Board certification that financial reporting procedures are satisfactory and this is based on an appropriate professional opinion;
- Have the Board demonstrate that the applicant can with a high likelihood generate a sustainable net income surplus by year 3 of the projected period and maintain a reasonable cash position.
- Have a minimum financial risk rating of 3 within the first year of projections unless there are exceptional circumstances.

The full applications guide for wave 3 and wave 3a applicants is available on the Department of Health website at:

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4124372&chk=ANe7cw

Annex C: Code of conduct

Both the board of governors and the board of directors should operate a code of conduct. This will ensure high standards of probity and responsibility and will make it clear how potential conflicts of interests are dealt with. There are several to choose from. Set out below are the Nolan principles of public life and the NVCO adaptation of that. The Co-operative Union's Code of Best Practice is used extensively throughout the consumer co-operative movement and is currently being updated.

Nolan Principles: - the seven principles of public life

Selflessness

Holders of public office should take decisions solely in terms of the public interest. They should not do so to gain financial or other material benefits for themselves, their family or their friends.

Integrity

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

Objectivity

In carrying out public business, including making public appointments, awarding contracts or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability

Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness

Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty

Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership

Holders of public office should promote and support these principles by leadership and example.

Sample code of conduct for the National Council of Voluntary Organisations (adapted from the 'Nolan Principles')

1. Board members must act with probity, due prudence and should take and consider professional advice on anything in which the board members do not have expertise themselves.
2. A board member must administer the organisation and all its assets in the interest of current, potential and future beneficiaries.
3. Board members should hold themselves accountable to the organisation's stakeholders, including the public, for the board's decisions, its performance and the performance of the organisation.
4. Except where legally authorised, board members must not gain financial or other material benefit for themselves, their families or their friends from their trusteeship of the charity. Nor must a member attempt to use his/her status to gain customer advantage within the organisation (eg queue jump). The board should ensure that there are clear written policies on claiming expenses by members.
5. A board member must not place himself/herself under any financial or other obligation to outside individual organisations that might influence him/her in the performance of his/her official duties.
6. Board members should conduct themselves in a manner that does not damage or undermine the reputation of the organisation, or its staff individually or collectively and should not take part in any activity in conflict with the objects or that might damage the reputation of the organisation.
7. Board members must make decisions together and take joint responsibility for them. The extent to which any one board member or a small group of members is empowered to speak for or take action on behalf of the organisation or the board must (subject to any specific constitutional rules) be a matter for all members to decide together. Such decisions must be recorded.
8. Board members who sit as the nominee or representative of a group or organisation must accept that their sole responsibility is to the organisation of which they are a board member, not to their nominated group or body.

Copies can be found at www.ncl.ac.uk/nuls/research/wpapers/bridge1.html

The Co-operative Union's Code of Best Practice can be found at www.co-opunion.coop/live/images/cme_resources/Public/governance.

Annex D: Model Constitution

Monitor are reviewing the model constitution in the light of a public consultation conducted in Autumn 2005. A revised constitution is expected to be available on Monitor's website from February 2006.

Annex E: Model Election Rules

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1. Interpretation

Part 2 – Timetable for election

2. Timetable
3. Computation of time

Part 3 – Returning officer

4. Returning officer
5. Staff
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Part 4 - Stages Common to Contested and Uncontested Elections

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Part 8 – Disposal of documents

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Part 9 – Death of a candidate during a contested election

- fpp54. Countermand or abandonment of poll on death of candidate
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Part 10 – Election expenses and publicity

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55. Expenses incurred by candidates
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- 58. Publicity about election by the corporation
- 59. Information about candidates for inclusion with voting documents
- 60. Meaning of “for the purposes of an election”

Part 11 – Questioning elections and irregularities

- 61. Application to question an election

Part 12 – Miscellaneous

- 62. Secrecy
- 63. Prohibition of disclosure of vote
- 64 Disqualification
- 65 Delay in postal service through industrial action or unforeseen event

Part 1 - Interpretation

1. Interpretation – (1) In these rules, unless the context otherwise requires -

“corporation” means the public benefit corporation subject to this constitution;

“election” means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the board of governors;

“the regulator” means the Independent Regulator for NHS foundation trusts; and

“the 2003 Act” means the Health and Social Care (Community Health and Standards) Act 2003.

(2) Other expressions used in these rules and in Schedule 1 to the Health and Social Care (Community Health and Standards) Act 2003 have the same meaning in these rules as in that Schedule.

Part 2 – Timetable for election

2. Timetable - The proceedings at an election shall be conducted in accordance with the following timetable.

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination papers to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day

	of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time - (1) In computing any period of time for the purposes of the timetable -

- (a) a Saturday or Sunday;
- (b) Christmas day, Good Friday, or a bank holiday, or
- (c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

(2) In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

Part 3 – Returning officer

4. Returning officer – (1) Subject to rule 64, the returning officer for an election is to be appointed by the corporation.

(2) Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff – Subject to rule 64, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure - The corporation is to pay the returning officer –

- (a) any expenses incurred by that officer in the exercise of his or her functions under these rules,
- (b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation – The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

Part 4 - Stages Common to Contested and Uncontested Elections

8. Notice of election – The returning officer is to publish a notice of the election stating –

- (a) the constituency, or class within a constituency, for which the election is being held,
- (b) the number of members of the board of governors to be elected from that constituency, or class within that constituency,
- (c) the details of any nomination committee that has been established by the corporation,
- (d) the address and times at which nomination papers may be obtained;

- (e) the address for return of nomination papers and the date and time by which they must be received by the returning officer,
- (f) the date and time by which any notice of withdrawal must be received by the returning officer
- (g) the contact details of the returning officer, and
- (h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates – (1) Each candidate must nominate themselves on a single nomination paper.

(2) The returning officer-

- (a) is to supply any member of the corporation with a nomination paper, and
- (b) is to prepare a nomination paper for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer.

10. Candidate's particulars – (1) The nomination paper must state the candidate's -

- (a) full name,
- (b) contact address in full, and
- (c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests – The nomination paper must state –

- (a) any financial interest that the candidate has in the corporation, and
- (b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility – The nomination paper must include a declaration made by the candidate–

- (a) that he or she is not prevented from being a member of the board of governors by paragraph 8 of Schedule 1 of the 2003 Act or by any provision of the constitution; and,
- (b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate – The nomination paper must be signed and dated by the candidate, indicating that –

- (a) they wish to stand as a candidate,

- (b) their declaration of interests as required under rule 11, is true and correct, and
- (c) their declaration of eligibility, as required under rule 12, is true and correct.

14. Decisions as to the validity of nomination – (1) Where a nomination paper is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer-

- (a) decides that the candidate is not eligible to stand,
- (b) decides that the nomination paper is invalid,
- (c) receives satisfactory proof that the candidate has died, or
- (d) receives a written request by the candidate of their withdrawal from candidacy.

(2) The returning officer is entitled to decide that a nomination paper is invalid only on one of the following grounds -

- (a) that the paper is not received on or before the final time and date for return of nomination papers, as specified in the notice of the election,
- (b) that the paper does not contain the candidate's particulars, as required by rule 10;
- (c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,
- (d) that the paper does not include a declaration of eligibility as required by rule 12, or
- (e) that the paper is not signed and dated by the candidate, as required by rule 13.

(3) The returning officer is to examine each nomination paper as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

(4) Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination paper, stating the reasons for their decision.

(5) The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination paper.

15. Publication of statement of candidates – (1) The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

(2) The statement must show –

- (a) the name, contact address, and constituency or class within a constituency of each candidate standing, and
- (b) the declared interests of each candidate standing,

as given in their nomination paper.

(3) The statement must list the candidates standing for election in alphabetical order by surname.

(4) The returning officer must send a copy of the statement of candidates and copies of the nomination papers to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination papers –

(1) The corporation is to make the statements of the candidates and the nomination papers supplied by the returning officer under rule 15(4) available for inspection by members of the public free of charge at all reasonable times.

(2) If a person requests a copy or extract of the statements of candidates or their nomination papers, the corporation is to provide that person with the copy or extract free of charge.

17. Withdrawal of candidates - A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election – (1) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the board of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

(2) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the board of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

(3) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be board of governors, then –

- (a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and
- (b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

Part 5 – Contested elections

19. Poll to be taken by ballot – (1) The votes at the poll must be given by secret ballot.

(2) The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

20. The ballot paper – (1) The ballot of each voter is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

(2) Every ballot paper must specify –

- (a) the name of the corporation,
- (b) the constituency, or class within a constituency, for which the election is being held,
- (c) the number of members of the board of governors to be elected from that constituency, or class within that constituency,
- (d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
- (e) instructions on how to vote,
- (f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and
- (g) the contact details of the returning officer.

(3) Each ballot paper must have a unique identifier.

(4) Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies) – (1) In respect of an election for a public or patient constituency a declaration of identity must be issued with each ballot paper.

(2) The declaration of identity is to include a declaration –

- (a) that the voter is the person to whom the ballot paper was addressed,
- (b) that the voter has not marked or returned any other voting paper in the election, and
- (c) for a member of the public or patient constituency, of the particulars of that member's qualification to vote as a member of the constituency or class within a constituency for which the election is being held.

(3) The declaration of identity is to include space for –

- (a) the name of the voter,
- (b) the address of the voter,
- (c) the voter's signature, and
- (d) the date that the declaration was made by the voter.

(4) The voter must be required to return the declaration of identity together with the ballot paper.

(5) The declaration of identity must caution the voter that, if it is not returned with the ballot paper, or if it is returned without being correctly completed, the voter's ballot paper may be declared invalid.

Action to be taken before the poll

22. List of eligible voters – (1) The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 26 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

(2) The list is to include, for each member, a mailing address where his or her ballot paper is to be sent.

23. Notice of poll - The returning officer is to publish a notice of the poll stating–

- (a) the name of the corporation,
- (b) the constituency, or class within a constituency, for which the election is being held,
- (c) the number of members of the board of governors to be elected from that constituency, or class with that constituency,
- (d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
- (e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,
- (f) the address for return of the ballot papers, and the date and time of the close of the poll,
- (g) the address and final dates for applications for replacement ballot papers, and
- (h) the contact details of the returning officer.

24. Issue of voting documents by returning officer – (1) As soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following documents to each member of the corporation named in the list of eligible voters–

- (a) a ballot paper and ballot paper envelope,
- (b) a declaration of identity (if required),
- (c) information about each candidate standing for election, pursuant to rule 59 of these rules, and
- (d) a covering envelope.

(2) The documents are to be sent to the mailing address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope – (1) The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

(2) The covering envelope is to have –

- (a) the address for return of the ballot paper printed on it, and
- (b) pre-paid postage for return to that address.

(3) There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

- (a) the completed declaration of identity if required, and
- (b) the ballot paper envelope, with the ballot paper sealed inside it.

The poll

26. Eligibility to vote – An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

27. Voting by persons who require assistance – (1) The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

(2) Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

28. Spoilt ballot papers (1) – If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to a “spoilt ballot paper”), that voter may apply to the returning officer for a replacement ballot paper.

(2) On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

(3) The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she –

- (a) is satisfied as to the voter’s identity, and
- (b) has ensured that the declaration of identity, if required, has not been returned.

(4) After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list (“the list of spoilt ballot papers”) –

- (a) the name of the voter, and
- (b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and
- (c) the details of the unique identifier of the replacement ballot paper.

29. Lost ballot papers – (1) Where a voter has not received his or her ballot paper by the fourth day before the close of the poll, that voter may apply to the returning officer for a replacement ballot paper.

(2) The returning officer may not issue a replacement ballot paper for a lost ballot paper unless he or she –

- (a) is satisfied as to the voter's identity,
- (b) has no reason to doubt that the voter did not receive the original ballot paper, and
- (c) has ensured that the declaration of identity if required has not been returned.

(3) After issuing a replacement ballot paper for a lost ballot paper, the returning officer shall enter in a list ("the list of lost ballot papers") –

- (a) the name of the voter, and
- (b) the details of the unique identifier of the replacement ballot paper.

30. Issue of replacement ballot paper– (1) If a person applies for a replacement ballot paper under rule 28 or 29 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue a replacement ballot paper unless, in addition to the requirements imposed rule 28(3) or 29(2), he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

(2) After issuing a replacement ballot paper under this rule, the returning officer shall enter in a list ("the list of tendered ballot papers") –

- (a) the name of the voter, and
- (b) the details of the unique identifier of the replacement ballot paper issued under this rule.

31. Declaration of identity for replacement ballot papers (public and patient constituencies) – (1) In respect of an election for a public or patient constituency a declaration of identity must be issued with each replacement ballot paper.

(2) The declaration of identity is to include a declaration –

- (a) that the voter has not voted in the election with any ballot paper other than the ballot paper being returned with the declaration, and
- (b) of the particulars of that member's qualification to vote as a member of the public or patient constituency, or class within a constituency, for which the election is being held.

(3) The declaration of identity is to include space for –

- (a) the name of the voter,
- (b) the address of the voter,
- (c) the voter's signature, and

(d) the date that the declaration was made by the voter.

(4) The voter must be required to return the declaration of identity together with the ballot paper.

(5) The declaration of identity must caution the voter that if it is not returned with the ballot paper, or if it is returned without being correctly completed, the replacement ballot paper may be declared invalid.

Procedure for receipt of envelopes

32. Receipt of voting documents – (1) Where the returning officer receives a –

- (a) covering envelope, or
- (b) any other envelope containing a declaration of identity if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 33 and 34 are to apply.

(2) The returning officer may open any ballot paper envelope for the purposes of rules 33 and 34, but must make arrangements to ensure that no person obtains or communicates information as to –

- (a) the candidate for whom a voter has voted, or
- (b) the unique identifier on a ballot paper.

(3) The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

33. Validity of ballot paper – (1) A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly completed, signed, and dated.

(2) Where the returning officer is satisfied that paragraph (1) has been fulfilled, he or she is to –

- (a) put the declaration of identity if required in a separate packet, and
- (b) put the ballot paper aside for counting after the close of the poll.

(3) Where the returning officer is not satisfied that paragraph (1) has been fulfilled, he or she is to –

- (a) mark the ballot paper “disqualified”,
- (b) if there is a declaration of identity accompanying the ballot paper, mark it as “disqualified” and attach it the ballot paper,
- (c) record the unique identifier on the ballot paper in a list (the “list of disqualified documents”); and

- (d) place the document or documents in a separate packet.

34. Declaration of identity but no ballot paper (public and patient constituency)

– Where the returning officer receives a declaration of identity if required but no ballot paper, the returning officer is to –

- (a) mark the declaration of identity “disqualified”,
- (b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper; and
- (c) place the declaration of identity in a separate packet.

35. Sealing of packets – As soon as is possible after the close of the poll and after the completion of the procedure under rules 33 and 34, the returning officer is to seal the packets containing–

- (a) the disqualified documents, together with the list of disqualified documents inside it,
- (b) the declarations of identity if required,
- (c) the list of spoilt ballot papers,
- (d) the list of lost ballot papers,
- (e) the list of eligible voters, and
- (f) the list of tendered ballot papers.

Part 6 - Counting the votes

stv36. Interpretation of Part 6 – In Part 6 of these rules –

“continuing candidate” means any candidate not deemed to be elected, and not excluded,

“count” means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

“deemed to be elected” means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

“mark” means a figure, an identifiable written word, or a mark such as “X”,

“non-transferable vote” means a ballot paper –

- (a) on which no second or subsequent preference is recorded for a continuing candidate, or
- (b) which is excluded by the returning officer under rule stv44(4) below,

“preference” as used in the following contexts has the meaning assigned below–

- (a) “first preference” means the figure “1” or any mark or word which clearly indicates a first (or only) preference,

- (b) “next available preference” means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and
- (c) in this context, a “second preference” is shown by the figure “2” or any mark or word which clearly indicates a second preference, and a third preference by the figure “3” or any mark or word which clearly indicates a third preference, and so on,

“quota” means the number calculated in accordance with rule stv41 below,

“surplus” means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable papers from the candidate who has the surplus,

“stage of the count” means –

- (a) the determination of the first preference vote of each candidate,
- (b) the transfer of a surplus of a candidate deemed to be elected, or
- (c) the exclusion of one or more candidates at any given time,

“transferable paper” means a ballot paper on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

“transferred vote” means a vote derived from a ballot paper on which a second or subsequent preference is recorded for the candidate to whom that paper has been transferred, and

“transfer value” means the value of a transferred vote calculated in accordance with paragraph (4) or (7) of rule stv42 below.

37. Arrangements for counting of the votes – The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

38. The count – (1) The returning officer is to –

- (a) count and record the number of ballot papers that have been returned, and
- (b) count the votes according to the provisions in this Part of the rules.

(2) The returning officer, while counting and recording the number of ballot papers and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper.

(3) The returning officer is to proceed continuously with counting the votes as far as is practicable.

Stv39. Rejected ballot papers – (1) Any ballot paper –

- (a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
- (b) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,
- (c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
- (d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

(2) The returning officer is to endorse the word “rejected” on any ballot paper which under this rule is not to be counted.

(3) The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of paragraph (1).

fpp39. Rejected ballot papers – (1) Any ballot paper –

- (a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
- (b) on which votes are given for more candidates than the voter is entitled to vote,
- (c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
- (d) which is unmarked or rejected because of uncertainty,

shall, subject to paragraphs (2) and (3) below, be rejected and not counted.

(2) Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

(3) A ballot paper on which a vote is marked –

- (a) elsewhere than in the proper place,
- (b) otherwise than by means of a clear mark,
- (c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

(4) The returning officer is to –

- (a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and

- (b) in the case of a ballot paper on which any vote is counted under paragraph (2) or (3) above, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

(5) The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings –

- (a) does not bear proper features that have been incorporated into the ballot paper,
- (b) voting for more candidates than the voter is entitled to,
- (c) writing or mark by which voter could be identified, and
- (d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

stv40. First stage – (1) The returning officer is to sort the ballot papers into parcels according to the candidates for whom the first preference votes are given.

(2) The returning officer is to then count the number of first preference votes given on ballot papers for each candidate, and is to record those numbers.

(3) The returning officer is to also ascertain and record the number of valid ballot papers.

stv41. The quota – (1) The returning officer is to divide the number of valid ballot papers by a number exceeding by one the number of members to be elected.

(2) The result, increased by one, of the division under paragraph (1) above (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).

(3) At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in paragraphs (1) to (3) of rule stv44 has been complied with.

stv42. Transfer of votes – (1) Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot papers on which first preference votes are given for that candidate into sub-parcels so that they are grouped –

- (a) according to next available preference given on those papers for any continuing candidate, or
- (b) where no such preference is given, as the sub-parcel of non-transferable votes.

(2) The returning officer is to count the number of ballot papers in each parcel referred to in paragraph (1) above.

(3) The returning officer is, in accordance with this rule and rule stv43 below, to transfer each sub-parcel of ballot papers referred to in paragraph (1)(a) to the candidate for whom the next available preference is given on those papers.

(4) The vote on each ballot paper transferred under paragraph (3) above shall be at a value (“the transfer value”) which –

- (a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and
- (b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot papers on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

(5) Where at the end of any stage of the count involving the transfer of ballot papers, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot papers in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped –

- (a) according to the next available preference given on those papers for any continuing candidate, or
- (b) where no such preference is given, as the sub-parcel of non-transferable votes.

(6) The returning officer is, in accordance with this rule and rule stv43 below, to transfer each sub-parcel of ballot papers referred to in paragraph (5)(a) to the candidate for whom the next available preference is given on those papers.

(7) The vote on each ballot paper transferred under paragraph (6) shall be at –

- (a) a transfer value calculated as set out in paragraph (4)(b) above, or
- (b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

(8) Each transfer of a surplus constitutes a stage in the count.

(9) Subject to paragraph (10), the returning officer shall proceed to transfer transferable papers until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

(10) Transferable papers shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are –

- (a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or
- (b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

(11) This rule does not apply at an election where there is only one vacancy.

stv43. Supplementary provisions on transfer – (1) If, at any stage of the count, two or more candidates have surpluses, the transferable papers of the candidate with the highest surplus shall be transferred first, and if –

- (a) The surpluses determined in respect of two or more candidates are equal, the transferable papers of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and
- (b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable papers of the candidate on whom the lot falls shall be transferred first.

(2) The returning officer shall, on each transfer of transferable papers under rule stv42 above –

- (a) record the total value of the votes transferred to each candidate,
- (b) add that value to the previous total of votes recorded for each candidate and record the new total,
- (c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and
- (d) compare—
 - (i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with
 - (ii) the recorded total of valid first preference votes.

(3) All ballot papers transferred under rule stv42 or stv44 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that paper or, as the case may be, all the papers in that sub-parcel.

(4) Where a ballot paper is so marked that it is unclear to the returning officer at any stage of the count under rule stv42 or stv44 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot paper as a non-transferable vote; and votes on a ballot paper shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

stv44. Exclusion of candidates – (1) If—

- (a) all transferable papers which under the provisions of rule stv42 above (including that rule as applied by paragraph (11) below) and this rule are required to be transferred, have been transferred, and
- (b) subject to rule stv45 below, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where paragraph (12) below applies, the candidates with the then lowest votes).

(2) The returning officer shall sort all the ballot papers on which first preference votes are given for the candidate or candidates excluded under paragraph (1) above into two sub-parcels so that they are grouped as—

- (a) ballot papers on which a next available preference is given, and
- (b) ballot papers on which no such preference is given (thereby including ballot papers on which preferences are given only for candidates who are deemed to be elected or are excluded).

(3) The returning officer shall, in accordance with this rule and rule stv43 above, transfer each sub-parcel of ballot papers referred to in paragraph (2)(a) above to the candidate for whom the next available preference is given on those papers.

(4) The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

(5) If, subject to rule stv45 below, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable papers, if any, which had been transferred to any candidate excluded under paragraph (1) above into sub-parcels according to their transfer value.

(6) The returning officer shall transfer those papers in the sub-parcel of transferable papers with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those papers (thereby passing over candidates who are deemed to be elected or are excluded).

(7) The vote on each transferable paper transferred under paragraph (6) above shall be at the value at which that vote was received by the candidate excluded under paragraph (1) above.

(8) Any papers on which no next available preferences have been expressed shall be set aside as non-transferable votes.

(9) After the returning officer has completed the transfer of the ballot papers in the sub-parcel of ballot papers with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot papers with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under paragraph (1) above.

(10) The returning officer shall after each stage of the count completed under this rule—

- (a) record –
 - (i) the total value of votes, or
 - (ii) the total transfer value of votes transferred to each candidate,
- (b) add that total to the previous total of votes recorded for each candidate and record the new total,
- (c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and
- (d) compare—

- (i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with
- (ii) the recorded total of valid first preference votes.

(11) If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with paragraphs (5) to (10) of rule stv42 and rule stv43.

(12) Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

(13) If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest—

- (a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and
- (b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

stv45. Filling of last vacancies – (1) Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

(2) Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

(3) Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

stv46. Order of election of candidates – (1) The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule stv42(10) above.

(2) A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

(3) Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

(4) Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

fpp46. Equality of votes – Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

Part 7 – Final proceedings in contested and uncontested elections

fpp47. Declaration of result for contested elections – (1) In a contested election, when the result of the poll has been ascertained, the returning officer is to –

- (a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the board of governors from the constituency, or class within a constituency, for which the election is being held to be elected,
 - (b) give notice of the name of each candidate who he or she has declared elected—
 - (i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 4(4) of the 2003 Act, to the chairman of the NHS Trust, or
 - (ii) in any other case, to the chairman of the corporation; and
 - (c) give public notice of the name of each candidate whom he or she has declared elected.
- (2) The returning officer is to make –
- (a) the total number of votes given for each candidate (whether elected or not), and
 - (b) the number of rejected ballot papers under each of the headings in rule fpp39(5),

available on request.

stv47. Declaration of result for contested elections – (1) In a contested election, when the result of the poll has been ascertained, the returning officer is to—

- (a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,
- (b) give notice of the name of each candidate who he or she has declared elected –
 - (i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 4(4) of the 2003 Act, to the chairman of the NHS Trust, or
 - (ii) in any other case, to the chairman of the corporation, and
- (c) give public notice of the name of each candidate who he or she has declared elected.

(2) The returning officer is to make –

- (a) the number of first preference votes for each candidate whether elected or not,
- (b) any transfer of votes,
- (c) the total number of votes for each candidate at each stage of the count at which such transfer took place,
- (d) the order in which the successful candidates were elected, and
- (e) the number of rejected ballot papers under each of the headings in rule stv39(1),

available on request.

48. Declaration of result for uncontested elections – In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election –

- (a) declare the candidate or candidates remaining validly nominated to be elected,
- (b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and
- (c) give public notice of the name of each candidate who he or she has declared elected.

Part 8 – Disposal of documents

49. Sealing up of documents relating to the poll – (1) On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets –

- (a) the counted ballot papers,
- (b) the ballot papers endorsed with “rejected in part”,
- (c) the rejected ballot papers, and
- (d) the statement of rejected ballot papers.

(2) The returning officer must not open the sealed packets of –

- (a) the disqualified documents, with the list of disqualified documents inside it,
- (b) the declarations of identity,
- (c) the list of spoilt ballot papers,
- (d) the list of lost ballot papers,
- (e) the list of eligible voters, and
- (f) the list of tendered ballot papers.

(3) The returning officer must endorse on each packet a description of –

- (a) its contents,
- (b) the date of the publication of notice of the election,
- (c) the name of the corporation to which the election relates, and
- (d) the constituency, or class within a constituency, to which the election relates.

50. Delivery of documents – Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 49, the returning officer is to forward them to the chair of the corporation.

51. Forwarding of documents received after close of the poll – Where –

- (a) any voting documents are received by the returning officer after the close of the poll, or
- (b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or
- (c) any applications for replacement ballot papers are made too late to enable new ballot papers to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

52. Retention and public inspection of documents – (1) The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the regulator, cause them to be destroyed.

(2) With the exception of the documents listed in rule 53(1), the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

(3) A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

53. Application for inspection of certain documents relating to an election –

(1) The corporation may not allow the inspection of, or the opening of any sealed packet containing –

- (a) any rejected ballot papers, including ballot papers rejected in part,
- (b) any disqualified documents, or the list of disqualified documents,
- (c) any counted ballot papers,
- (d) any declarations of identity, or
- (e) the list of eligible voters,

by any person without the consent of the Regulator.

(2) A person may apply to the Regulator to inspect any of the documents listed in (1), and the Regulator may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

(3) The Regulator's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

- (a) persons,
- (b) time,
- (c) place and mode of inspection,
- (d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

(4) On an application to inspect any of the documents listed in paragraph (1), –

- (a) in giving its consent, the regulator, and
- (b) and making the documents available for inspection, the corporation,

must ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

- (i) that his or her vote was given, and
- (ii) that the regulator has declared that the vote was invalid.

Part 9 – Death of a candidate during a contested election

fpp54. Countermand or abandonment of poll on death of candidate – (1) If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to

- (a) countermand notice of the poll, or, if ballot papers have been issued, direct that the poll be abandoned within that constituency or class, and
- (b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

(2) Where a new election is ordered under paragraph (1), no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

(3) Where a poll is abandoned under paragraph (1)(a), paragraphs (4) to (7) are to apply.

(4) The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 33 and 34, and is to make up separate sealed packets in accordance with rule 35.

(5) The returning officer is to –

- (a) count and record the number of ballot papers that have been received, and
 - (b) seal up the ballot papers into packets, along with the records of the number of ballot papers.
- (6) The returning officer is to endorse on each packet a description of –
- (a) its contents,
 - (b) the date of the publication of notice of the election,
 - (c) the name of the corporation to which the election relates, and
 - (d) the constituency, or class within a constituency, to which the election relates.
- (7) Once the documents relating to the poll have been sealed up and endorsed pursuant to paragraphs (4) to (6), the returning officer is to deliver them to the chairman of the corporation, and rules 52 and 53 are to apply.

stv54. Countermand or abandonment of poll on death of candidate – (1) If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to –

- (a) publish a notice stating that the candidate has died, and
 - (b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –
 - (i) ballot papers which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and
 - (ii) ballot papers which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.
- (2) The ballot papers which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot papers pursuant to rule 49(1)(a).

Part 10 – Election expenses and publicity

Election expenses

55. Election expenses – Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application to the regulator under Part 11 of these rules.

56 Expenses and payments by candidates - A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to –

- (a) personal expenses,

- (b) travelling expenses, and expenses incurred while living away from home, and
- (c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of [£100].

57. Election expenses incurred by other persons – (1) No person may -

- (a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or
- (b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

(2) Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 58 and 59.

Publicity

58. Publicity about election by the corporation – (1) The corporation may –

- (a) compile and distribute such information about the candidates, and
- (b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

(2) Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 59, must be –

- (a) objective, balanced and fair,
- (b) equivalent in size and content for all candidates,
- (c) compiled and distributed in consultation with all of the candidates standing for election, and
- (d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

(3) Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

59. Information about candidates for inclusion with voting documents - (1)

The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

(2) The information must consist of –

- (a) a statement submitted by the candidate of no more than [250] words, [and]
- [(b) a photograph of the candidate.]

60. Meaning of “for the purposes of an election” - (1) In this Part, the phrase “for the purposes of an election” means with a view to, or otherwise in connection with, promoting or procuring a candidate’s election, including the prejudicing of another candidate’s electoral prospects; and the phrase “for the purposes of a candidate’s election” is to be construed accordingly.

(2) The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

Part 11 – Questioning elections and the consequence of irregularities

61. Application to question an election – (1) An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to the regulator.

(2) An application may only be made once the outcome of the election has been declared by the returning officer.

(3) An application may only be made to the Regulator by -

- (a) a person who voted at the election or who claimed to have had the right to vote, or
- (b) a candidate, or a person claiming to have had a right to be elected at the election.

(4) The application must –

- (a) describe the alleged breach of the rules or electoral irregularity, and
- (b) be in such a form as the Regulator may require.

(5) The application must be presented in writing within 21 days of the declaration of the result of the election.

(6) If the Regulator requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

a. The Regulator shall delegate the determination of an application to a person or persons to be nominated for the purpose of the Regulator.

b. The determination by the person or persons nominated in accordance with Rule 61(7) shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

c. The Regulator may prescribe rules of procedure for the determination of an application including costs.

Part 12 – Miscellaneous

62. Secrecy – (1) The following persons –

- (a) the returning officer,
- (b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to –

- (i) the name of any member of the corporation who has or has not been given a ballot paper or who has or has not voted,
- (ii) the unique identifier on any ballot paper,
- (iii) the candidate(s) for whom any member has voted.

(2) No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter.

(3) The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

63. Prohibition of disclosure of vote – No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

64. Disqualification – A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is –

- (a) a member of the corporation,
- (b) an employee of the corporation,
- (c) a director of the corporation, or
- (d) employed by or on behalf of a person who has been nominated for election.

65. Delay in postal service through industrial action or unforeseen event – If industrial action, or some other unforeseen event, results in a delay in –

- (a) the delivery of the documents in rule 24, or
- (b) the return of the ballot papers and declarations of identity,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll, with the agreement of the Regulator.

Annex F: Acknowledgements and References

This sourcebook has been put together by the Department of Health drawing on a wide range of contributions from business, public and third sector organisations. The Department has been particularly grateful for the significant contribution made from the External Reference Group on Governance who have provided critical input into the thinking in this document and the wider policy around NHS foundation trusts. The External Reference Group consists of:

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Pauline Green	Co-operative Union
Peter Couchman	Oxford, Swindon & Gloucester Co-op
Jonathan Bland	Social Enterprise Coalition
Mark Sesnan	Greenwich Leisure
Geraint Day	Institute of Directors
Sue Slipman	Foundation trust Network
Mike Hudson	Compass Partnership
Greg Parston	Office of Public Management
Johnston Birchall	University of Stirling
Cliff Mills	Cobbetts Solicitors
Nick Goodman	Electoral Reform Society
Cliff Prior	Rethink
Chris Dabbs	Futurologist
Adrian Henriques	Consultant
Andrea Westall	New Economics Foundation
Sharon Grant	Commission for Patient and Public Involvement in Health
Bob Sang	Sang Jacobsson
David Coats	TUC

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References

Chapter 1

- More detailed information is available on all aspects of policy on NHS Foundation trusts at:
<http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/SecondaryCare/NHSFoundationTrust/NHSFoundationTrustArticle/fs/en>
- The Health and Social Care (Community Health and Standards) Act 2003 can be found at <http://www.legislation.hmso.gov.uk/acts/acts2003/20030043.htm>
- Applying for NHS Foundation Trust Status: Guide for Wave 3 Applications.
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4124372&chk=ANe7cw

Chapter 3

- The Bradford Teaching Hospitals NHS Foundation trust website can be found at www.bradfordhospitals.nhs.uk
- The Moorfields Eye Hospital NHS Foundation trust website can be found at www.moorfields.org.uk
- *A fuller account of potential patient benefits can be found at Herzlinger R (1996) "Can Public Trust in Non-Profits and Governments be Restored? Harvard Business Review, March-April 1996).*
- The Britannia Building Society can be contacted via website at www.bsa.org.uk for further details of member panels.
- The Nationwide Building Society can be contacted for further details of the benefits of memberships. Their details can be found at www.nationwide.co.uk
- Details of the Community Advisory Forum can be obtained from Newcastle Hospitals at www.newcastle-hospitals.org.uk
- Further information on expert patient programmes can be found at www.4ps.com and at www.ohn.gov.uk/ohn/people/expert.htm
- The contact details for the blood donor service can be found at www.blood.co.uk.
- Details of the staff Central Councils can be obtained from John Lewis plc at www.johnlewisjobs.com
- Further details on Greenwich Leisure can be found at www.employee-ownership.org.uk

- www.lgmb.co.uk gives further details of the Roberts Bell Associates work on Involving the Public.
- Details of the advice given to school can be found at www.dfes.gov.uk
- www.huddweb.demon.co.uk gives the contact details of Calderdale and Huddersfield NHS Trust.
- RNID (formally The Royal National Institute for the Deaf people) www.rnid.org.uk provides details of their membership.
- Lincoln Co-operative society website can be found at www.lincolncoop.co.uk
- Kings College Hospital website can be found at www.kcl.ac.uk
- Further details of the scrap metal soul can be found at www.communityarts.net/readingroom/archive/35drumsticks.php - 17k - 29 Jun 2003.
- More information on the Garnett Foundation can be found at: Info@thegarnettfoundation.com
- www.modern.nhs.uk – a guide to using Discovery Interviews to improve care are available from NHS Responseline tel: 08701 555 455.
- The Leicester Royal Infirmary has explored a number of membership areas and can be contacted on www.uhl-r.nhs.uk/services/corporate/corporate_services.htm.
- The Bradford Hospitals website can be found at www.bradfordhospitals.nhs.uk
- The Royal National Institute for the Blind transcription centre (<http://www.rnib.org.uk/services/bra.htm>) provides both advice on and assistance with making information accessible.
- Some examples of the kinds of work undertaken by Investing in Children can be found on: <http://www.family-learning.org.uk/durhamcc/usp.nsf/pws/investing+in+children++iic++home+page>.
- www.lincolncoop.co.uk
- An evaluation of the People Panels can be found on www.cabinet-office.gov.uk/servicefirst/2000/panel/eval/index.htm.

Other useful research evidence can be found at:

- Birchall J and Simmons R (2001) "Member participation in mutuals; a theoretical model" in Birchall (ed) *The New Mutualism in Public Policy*, London, Routledge.

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- Joseph Rowntree Foundation (1999) *Developing Effective Community Involvement Strategies*, Ref 169
www.irf.org.uk/knowledge/findings/foundations/169.asp
- Commission for Patient and Public Involvement in Health (CPPiH)
www.cppih.org
- The Department of Health's guidance: Strengthening Accountability: Involving Patients and the Public-Policy and Practice Guidance for Section 11 of the Health and Social Care Act 2001 (www.doh.gov.uk/involvingpatients/invol-pat.htm) has a number of different approaches that can be used when dealing with traditionally hard to reach groups.
- The Improvement and Development Agency (www.idea.gov.uk) identifies more than 100 ways of engaging with the public, and gives a summary of the advantages, disadvantages and likely costs of each.
- The Department of Health Section 11 Health and Social Care Act 2002 Primary Care Trust Toolkit gives a detailed account of many methods of reaching a public audience (www.doh.gov.uk/involvingpatients/invol-pat.htm).
- The New Economics Foundation has drawn on its experience from around the world to create a handbook of proven participation techniques – *Participation Works*. – www.neweconomics.org
- The cabinet office has put out guidance on good practice on consultation by government departments. Many principles will apply here www.cabinet-office.gov.uk/servicefirst/2000/consult/code/ConsultationCode.htm
- Communication and consultation: Exploring ways for staff to involve people with dementia in developing services by Kate Allan is published for the Joseph Rowntree Foundation by The Policy Press and available from Marston Book Services, PO Box 269, Abingdon, Oxon OX14 4YN (01235 465500), price £16.95 plus £2.50 p&p. A summary of the findings is available on <http://www.irf.org.uk/pressroom/releases/160501.asp>.
- Kretzmann, John and John McKnight. Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets. Institute for Policy Research, Northwestern University (1993).

Chapter 4

- The Countess of Chester NHS Foundation trust website is at www.coch.org
- The Royal Devon and Exeter NHS Foundation trust website is at www.rdehospital.nhs.uk
- The Homerton University Hospital NHS Foundation trust website is at www.homerton.nhs.uk

- The Basildon and Thurrock NHS Foundation trust website is at www.basildonandthurrock.nhs.uk
- For more information about participation in the Puget Sound governance arrangements look at www@ghc.org
- Rubbens C, Monaghan P, Bonfiglioli E and Zadek S (2002), Impacts of Reporting: the role of social and sustainability reporting for organisational transformation, CSR Europe and Accountability, London.

Chapter 5

- further information on the NHS Appointments Commission can be found at http://www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/ModernisingProfessionalRegulation/NHSAppointmentsCommission/fs/en?CONTENT_ID=4052361&chk=wiAWEy
- further information on the NHS Confederation can be found at www.nhsconfed.org
- further information on the Department of Trade and Industry can be found at www.dti.gov.uk
- further information on the Audit Commission be found at www.audit-commission.gov.uk
- further information on the Institute of Directors can be found at www.iod.com

Chapter 6

- further information on the NHS Appointments Commission can be found at http://www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/ModernisingProfessionalRegulation/NHSAppointmentsCommission/fs/en?CONTENT_ID=4052361&chk=wiAWEy
- further information from the schools governing body can be found at www.governor.net.co.uk.
- further information from the Institute of Directors can be found at www.iod.com.
- further information from the charity commission can be found at www.trusteenetworks.org.uk.

Chapter 8

- NCVO Trustee Information Briefings: *Skills boards Require; Training for Trustees and Committees; Finding New Trustees; A Job Description for a Trustee* (SAE to Trustee and Governance Team)
- *The Trustee and Governance Briefing Pack*, available online or from the NCVO Trustee and Governance Team, May 2001
- Trustee board Development Programme Factfile *Designing a board induction programme* (Full Factfile £4.50 from Trustee and Governance Team)
- *The Twenty-Minute Guide to Becoming a Trustee* Help the Hospices (2000)
The Ford Partnership and Help the Hospices
- *Guide to board Development: Mentoring* (NCVO, available in 2001)
- Charity Commission *Welcome* leaflet for new trustees (available from the Charity Commission)
- NHS Appointments Commission
http://www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/ModernisingProfessionalRegulation/NHSAppointmentsCommission/fs/en?CONTENT_ID=4052361&chk=wiAWEy