A lifetime of specialist care

Royal Brompton & Harefield NHS
NHS Foundation Trust

Membership Strategy

2019-2021

1. The role of the Members

Section 4 of our Foundation Trust Constitution describes both the fundamental role of Members within the corporate structure of the Trust and also the requirement for the Membership base to be composed of three constituencies (staff, patients & carers, and public). The patient and public constituencies are further identified as those where "*such membership…be representative of those to whom the Trust provides services"*, in terms of not just age, gender and ethnicity but also of both the types of diseases for which we treat these patients and the geographical areas in which our patients reside.

From when Foundation Trusts were originally created, there has been an unwritten but underlying principle that local communities and patient cohorts have an informal claim to 'social' (not legal) ownership of a Foundation Trust from whose public services they benefit. This claim to 'social' ownership also extends to the staff who deliver these public services, in that they are particularly knowledgeable about these services and how they can be developed and sustained. Consequently, in order to recognize this sense of ownership, people living within these communities, or belonging to these patient cohorts, or providing these services, are all eligible to become a Member of a Foundation Trust.

Membership is therefore an important element through which we as a Foundation Trust are accountable to the communities we serve. Members are able to elect a set number of Governors from within each of their constituencies; the Governors elected in this way form the majority (17 out of 21) of a Council of Governors, which is chaired by the Chair of the unitary Trust Board. This Council in turn represents the interests of all the members, in particular holding the Trust's non-executive directors to account for the performance of the Trust Board.

Members however are not just an integral part of our Foundation Trust's governance structure: this strategy paper seeks to define a wider role that they can play through involvement in regular activities within the life of the Trust and also through support of the Trust in more strategic one-off events, and to identify the benefits both to the Members themselves as well as to the Trust.

2. Profile of the Members and Membership activities

Laid out below is a series of tables that quantify the make-up of the Membership base and which describe some of the activities in which Members have been involved. The data in these tables has been verified, where relevant, by Membership Engagement Services (the

contracted curator of our Membership database): this is the organisation to which we (and many other Foundation Trusts) outsource the hosting, maintenance and management of the database of our Members.

For the past decade, the size of the Membership base has remained relatively constant between 10-11,000 Members. Recruitment efforts - co-ordinated by the Trust Membership Manager, and principally in the form of volunteers and staff engaged in presenting Membership and its benefits to patients and members of the public – have over time slightly outweighed the numbers of Members unable (or deciding not) to continue their Membership.

Table 2.1 Breakdown of the present membership by constituency

Constituencies	Number (at November 2018)	% of total
Public	2765	*25%*
Patient	4574	*42%*
Staff	3598	*33%*
Total	**10,937**	-

Table 2.2 Comparison with other NHS Foundation Trusts (FY 2017/18)

Trust	Total
Royal Marsden Hospital NHS Foundation Trust	8,182
Liverpool Heart and Chest NHS Foundation Trust	9,800
Papworth NHS Foundation Trust	9,636
Chelsea and Westminster NHS Foundation Trust	17,193
Guys and St Thomas's NHS Foundation Trust	25,200
Royal Brompton & Harefield NHS Foundation Trust	***10,937***

Since membership of our Foundation Trust is an expression of support by patients and the public for the mission and the services of the Trust, we aim continually to increase the participation and involvement of Members. At present Members are invited to:

- Attend the combined meeting of the AGM of the Council of Governors and Members Annual Meeting;
- Receive the newsletter *'Patient Focus'* twice a year: this publication lays out the Trust's strategic plan, objectives and priorities: comments from Members are invited.
- Attend events, tours of the hospital and talks by Trust staff on clinical and research topics relating to heart and lung disease and treatments
- Become a hospital volunteer
- Become involved in fundraising for the charities associated with the Trust (principally the Royal Brompton and Harefield Hospital Charity, the Brompton Foundation and the Friends of the Royal Brompton).

Table 2.3 Members' attendance at the Members' and the Council of Governors Annual Meeting

Year	Attendance
2013	77
2014	64
2015	62
2016	69
2017	58
2018	35

Table 2.4 Attendance at Members' Events 2013 - 2018

Year	Event	Attendance
2013	Tour of the cardiac catheter laboratories at Harefield Hospital	25
2013	'*Advances in Cardiomyopathy*' Lecture	27
2014	'*Easy ways to help women (and men) be healthy and live longer*' lecture	24
2014	Tour of the cardiac catheter laboratories at Royal Brompton Hospital	20
2014	'*Diabetes and cardiovascular disease'* lecture	10
2015	'*Pacemakers in 2015 – what the future holds'* lecture	9
2015	Tour of the paediatric sleep laboratories	13
2015	'*Chronic Obstructive Airways disease'* lecture	17
2016	Tour of the primary ciliary dyskinesia department	2
2016	Tour of the hybrid operating theatre	12
2016	'*Lung transplantation*' lecture	10
2017	'*Managing chest pain: what options do we have if symptoms continue'* lecture	13
2018	'*Cardiac implantable devices'* lecture	3
2018	'*Cardiac arrhythmias'* lecture	8

3. The need for a new strategy

The strategy to date has been broadly about maintaining the size of the Membership base and in maintaining a regular connection with as many Members as are interested. However there a number of reasons why this approach should be revisited and refreshed:

i. *There is no particular rationale and purpose behind our current engagement efforts*, through which the Trust might potentially derive broader, more strategic benefits. We the Trust are fulfilling an obligation – ie engaging with our Members – but without a clear sense of what we and our Members respectively get from these efforts, they feel somewhat aimless and disjointed.

ii. *The current emphasis on trying to grow membership numbers should not be our predominant focus*. Annexes 1-3 to the Trust Constitution lay out a requirement for a minimum number of members within each of the three constituencies (300 public members, 400 staff members, 600 staff members). As table 2.1 above shows, these minimum numbers are currently comfortably exceeded for all three constituencies, by a factor of 8x to 10x. The comparison with other specialist hospitals' Membership bases suggests ours is above average in size. Although our recruitment efforts broadly need to offset the annual attrition rate of members (eg due to death, relocation etc), there does not appear to be a clear reason for focusing energy and time in trying to increase the size of the Membership base at the current time.

iii. *The number of Members engaging with the Trust is a very small proportion of the overall Membership base, and has been declining*. Tables 2.3 & 2.4 above show there has been a noticeable decrease in the numbers of Members since 2013 attending the Annual Meeting and Members' events, to a level of <0.5% of the total Membership. It could be argued that, as a specialist Trust, more than two-thirds of our patients come from beyond north-west London, and that for some services (eg transplantation, ECMO, interstitial lung disease), many patients live hundreds of miles from our hospitals, thereby limiting the percentage of Members willing to travel these distances for events and meetings. But this argument does not explain the decline in attendance at Membership events, nor in particular the relatively small number of Members who vote (mostly by post or by email) in Governor elections (typically 6-8%).

iv. *The Trust is embarking upon major developments ahead for which Members' support and positive engagement will be important*. For example, our collaboration with King's Health Partners (KHP) is likely to involve several consultations, both externally mandated (eg by NHS England) and also undertaken as part of our own internal planning and service definition exercises. But currently we do not have lines of engagement with our Members ready and strong enough effectively to mobilise their support for and input into this collaboration.

4. A refreshed set of strategic objectives for the Membership base

The lack of a practical, beneficial purpose to Membership - as outlined in section 3 above - is key to the way we approach the other three issues. To address it, we have identified below four strategic objectives for Membership, each with a description of how it brings benefits to the Trust. We believe that the flow of benefits however is not just one-way in favour of the Trust: although the addition of tactical or transactional benefits (eg access to NHS Discounts) is always welcome to Members, the primary motivation behind their involvement with the Trust is substantially philanthropic and altruistic. Members therefore are likely to welcome any development that means their efforts and time spent in supporting us yield a greater and more sustainable impact.

I. *Be a source of external influence*

We encourage many of our clinicians to be active in medical / healthcare colleges and societies, or on national clinical reference- or steering-groups, in order that they might exert influence on topics such as the reconfiguration of healthcare providers in a particular medical speciality (eg children's heart surgery). This not only helps improve standards and mechanisms for the delivery of care, but also it protects the Trust from potentially disruptive political agendas, from across the wider NHS and adjacent bodies and also from central Government.

Although Members may not be able to exert influence quite so overtly or so directly, they can still help the Trust in a number of other ways:

a. by being members of charities such as the British Lung Foundation, the British Heart Foundation, Asthma UK, the Somerville Foundation etc
b. By joining advisory panels of relevant government bodies
c. Members with positions within local Government bodies (eg as local councillors, or members of their local Healthwatch England) may be able to ensure that the Trust's services are portrayed or assessed fairly and accurately.

Members in the above organisations could serve as the 'eyes and ears' for the Trust in terms of providing intelligence on what agendas may be forming and around which particular personalities.

II. *Provide informed input into service developments or service quality assessments*

Since 40% of our Members are patients or carers, many with ongoing use of our services, they can provide input into how clinical services can be extended or improved from the basis of their own first-hand knowledge. Patients who are not Members can provide input too, but Member status will enable us to solicit this input more easily and on a repeated basis, and for the patient Member better to understand the broader context of our request. For example, the combining of multiple diagnostic and outpatient appointments into a single daycase visit may benefit from process design input from patient Members. Members can also feed into the Quality Impact Assessments (carried out to ensure productivity improvements such as those within the Trust's Darwin programme do not compromise the quality of patient care). The Trust will be able to cite these inputs as evidence of fuller compliance with the guidelines within the CQC's 'Responsive' and 'Well-led' assessment domains.

Our patients are frequently also patients of hospital Trusts who have referred them to us. There may be opportunities for us to work with these referral hospitals to improve the speed and smoothness of the referral pathway. Our patient Members are well-placed – eg via equivalent Membership events in these referring hospitals – to draw attention and gain commitment to such improvements, resulting in more secure and more productive referral relationships for our Trust.

III. *To support directly the Charities affiliated with the Trust*

The mission in broad terms of all of the Charities that are affiliated to our Trust is to seek donations and charitable grants to support the work of our two hospitals. Operationally they also rely to a greater or lesser extent on the commitment on a voluntary basis of helpers & organisers to stage fund-raising events, in order to maximise the portion of donations that goes to fund clinical or academic activities.

Anecdotal evidence suggests that the Membership base and (as an example) the Trust Charity's supporter base has shown a relatively low level of duplication. There is scope to encourage cross-over (both ways) of Members with supporters of all charities affiliated with the Trust, with the aim of deepening their relationship with the Trust, regardless of whether the currency of this relationship is in the form of a donation or of time spent supporting causes and agendas that help our hospitals. In the current climate of sensitivity around appropriate and consented use of personal data, any initiatives to create this cross-over must be carefully planned and executed. Early conversations with the Trust Charity however suggest that this could be a realistic and useful objective.

IV. *To volunteer time*

There is a volunteer presence at both our hospitals (eg help with wayfinding at the RBH Sydney St Reception, and patient & family liaison with Harefield ICU). However it is not part of a centrally planned and co-ordinated approach to developing volunteer

resources to address the broader range of demand. There are several tasks and roles across all areas of our hospitals for which no clinical background is required but which can substantially improve the quality of patient experience and alleviate pressure on 'front-line' clinical staff – for example wayfinding, patient & family liaison, administrative support, and even participating in the Trust's research trials as a member of a healthy volunteer control group.

Many Members have skills and experience from their current or prior careers that are more than sufficient to carry out these tasks and roles on a volunteer basis. Volunteering on a regular basis is not a realistic opportunity for Members living more than 30-60 minutes away from our hospitals – however an estimated 40-50% of our Members do live within this travel time distance. It will take time to make the most of this opportunity, in terms of determining which Members have the right combination of interests, capacity and capability to commit to a particular role, and in terms of identifying resources beyond the Membership Manager (eg within the Human Resources team and the operational teams) to support this. However we feel that as a strategic objective this will bring considerable benefit to both Members and the Trust.

V. *To ensure recruitment efforts maintain current size of Membership base*

As shown in table 2.2 above, we compare reasonably favourably with peer specialist Trusts in terms of our number of Members. Our primary strategic objectives (I to IV above) are focused on making our Members more active and deploying them more purposefully in ways that support the Trust's interests, and which by extension should give Members a greater sense of fulfilment and involvement with the Trust.

However, although recruitment of new members is a lower priority than these primary objectives, we should nevertheless at least maintain the current size of the Membership base, so as to ensure that the constituencies from which Governors are elected remain comfortably large enough for fair and representative elections to be carried out. This will continue to be the 'bread and butter' activity of the Membership Manager (although in the background to the actions and activities relating to the primary objectives). Our 'offer' to new Members will reflect not just transactional benefits (eg access to NHS discounts) but also the opportunities for purposeful support of the Trust, and for this reason we hope that our recruitment efforts will be more productive.

5. Activities to deliver the strategic objectives

1. Segment our membership base				
Purpose	Activity	Actions	Who responsible	By when
Identify sub-groups within our Membership base, who can be more precisely targeted / engaged in activities	1. Prospective – update membership application forms - paper and online – to enable capture of prospective Members' willingness to support the Membership's strategic objectives	1. Amended application forms to capture: o Members' interest in activities such as volunteering, inputting into service design / redesign, attending Charity events etc o If patient / carer, name of consultant whose care he / she / their relative is under o If patient / carer, name of referring hospital	Membership Manager	End June-19
	2. Retrospective – invite our c.4,500 existing patient /carer Members to become engaged in activities that support the Membership's strategic objectives	2. With Trust Communications' team input: o Create email / letter / item in Patient Focus, with description of activities / opportunities, rationale for Members' involvement, & request for Members' to provide 1-2 details regarding their treatment (eg name of consultant under whose care he / she was or is under) o Agree when & how often email / letter and web content should be sent / refreshed o Send email / letter / newsletter, then send again as agreed; capture response details within Members' database	Membership Manager / Trust Comms team Membership Manager	End May / end June-19

2. Be a source of external influence				
Purpose	Activity	Actions	Who responsible	By when
Anticipate and influence national service specifications and / or reconfigurations	1. Meet with divisional clinical leads for respiratory, cardiac and paediatric services (Dr Andrew Menzies-Gow, Dr Vias Markides, Dr Claire Hogg, Dr Jan Till and Dr Mark Mason) to agree plans to engage & support Members in roles that helping the Trust build and exert influence in future clinical service reviews, consultations or reconfigurations	1. For each division, to have identified and defined: ○ Opportunities (eg patient / layperson representative on a national clinical standards' setting group) where having influence would benefit the Trust ○ The external organisation(s) (eg medical charities) / groups through which influence can be exerted, for each opportunity ○ The actual influencing roles (& enabling mechanisms – eg sub-committee membership) that Members will play within each organisation / opportunity	Membership Manager / Director of Strategy / divisional clinical leads	End Dec-19
	2. 'Recruit' Members into influencing roles related to particular opportunities	2. For each actionable opportunity ○ Identify the sub-group of Members likely to be most interested / relevant to the opportunity (eg as defined by disease speciality – ie consultant overseeing care) ○ Each of them (by letter, signed by relevant consultant service leads) to be notified of the opportunity ○ If sufficient interest, meet with each Member and support them in their application for the position / role ○ In tandem with consultant service lead, gather any insights, intelligence etc from the Member(s) in these positions / roles	Membership Manager, divisional clinical leads, consultant service leads	End June-20

3. Provide input to internal service developments or service quality assessments				
Purpose	Activity	Actions	Who responsible	By when
Improve the design / planning of clinical service developments with input from Members	1. Identify internal service developments for which patient & public Members' involvement will be relevant & valuable	1. With site Directors, operational & Darwin programme leads: ○ List all imminent a) reconfigurations or expansions of existing services, b) new service developments, planned for next 12 months ○ From this list, prioritise the most relevant service reconfiguration / development for involving Members	Membership Manager / site Directors	End-August 19
	2. Involve Members in particular service development process	2. For each prioritised service reconfiguration / development: ○ Identify & confirm the sub-group of Members likely to be most useful & interested ○ Invite each of them (by letter, signed by relevant site Director and / or consultant clinical service lead) to serve on project / development team ○ From expressions of interest received, select Member(s) to serve on project team & introduce him / her / them to project lead ○ Debrief Member(s) and project lead at end of project	Membership Manager / site Directors / divisional clinical leads / project lead	End-Dec 19

4. Support the Trust's Charity (& other charities affiliated with the Trust)				
Purpose	Activity	Actions	Who responsible	By when
Maximise the number of Members who can become involved in the Trust Charity's activities Encourage existing fund-raisers and donors linked to the Trust Charity to become Members	1. Invite Members not yet affiliated with Trust Charity to attend Charity events	1. Working with Trust Charity: ○ Agree i) Trust Charity's 'offer' to Members and relevant content (eg invitation letter, Charity & Trust web pages etc), ii) programme (timing, frequency etc) for contact & follow-up of Members ○ Implement contact & follow-up of Members	Membership Manager / Membership Engagement Services / Trust Charity database manager	End-November 19
	2. Recruit fund-raisers / donors to become Members	2. Working with Trust Charity: ○ Agree Membership 'offer', relevant content and contact / follow-up programme ○ Implement contact & follow-up of donors / fund-raisers ○ Attend Charity events & offer Membership to event attendees (eg via a slot on the event programme or a stand at the event)	Membership Manager / Trust Charity's marketing manager: plus input from Trust Communications team	End-November 19
	3. Determine whether these activities can be extended to other charities affiliated with the Trust	3. After 1 year ○ Evaluate success / lessons learnt of this 'cross-promotion' recruitment approach with Trust Charity ○ Determine feasibility of this approach with other Trust-affiliated charities	Membership Manager / Trust Charity's marketing manager	October 20

5. Perform volunteer role				
Purpose	Activity	Actions	Who responsible	By when
A scheme for patient / public Members to complement regular staffing in non-clinical or administrative functions, enabling staff shortfalls (or 'spikes' in activity) to be accommodated (more or less) within existing budgets	1. Define volunteering opportunities and plan the recruitment process	1. With site Directors and other operational leads: ○ Define what kind of assistance Member volunteers could provide ○ Identify what clinical services or support functions / which Trust Divisions most need this assistance ○ Determine how best this can fit with / build on existing volunteering activities ○ Develop outline role specifications, candidate requirements, 'rota' options to fill each role, and training requirements ○ Agree process for promoting roles, shortlisting, interviewing, selecting and training Members ○ Determine quantum & type of resourcing required in each Trust Division to recruit, 'onboard', train and then co-ordinate Member volunteers	Membership Manager, with site Directors / other operational leads / HR business partners: plus input from Trust PALS & volunteering co-ordinator	End September 19
	2. Identify & recruit Members to fill these opportunities	2. Recruiting Members: ○ Identify two sub-groups of patient / public Members living <60 minutes journey time from HH and from RBH ○ Develop and send letter to both sub-groups, along with a listing of all the relevant roles (each with specifications & high-level candidate criteria) ○ Meet with interested Members to ensure 'fit' (both ways) for each role is right, then initiate onboarding and training, and begin role ○ Monitor and then evaluate the success (or otherwise) of the scheme and lessons learnt	Membership Manager / input from Trust Communications team / line managers for each role / HR business partners	End January 20